ANALYSIS OF BERNALILLO COUNTY'S SYSTEM FOR SERVING PEOPLE WITH MENTAL ILLNESSES AND CRIMINAL JUSTICE INVOLVEMENT

Fall 2019

A product of the Criminal Justice Coordinating Council's Diversion & Reentry Subcommittee

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Table of Contents

Introduction

In May of 2015 the Bernalillo County Commission passed the "Stepping Up" resolution (AR 2015-37 reprinted in Appendix J) which joined this jurisdiction with hundreds of other communities around the country expressing a similar commitment to an innovative emerging movement for change. The national Stepping Up Initiative, driven by the National Association of Counties (NACo), challenges elected officials and stakeholders in Bernalillo County to rethink the systems that are serving individuals with mental illness who are entangled in the criminal justice system. The county and its residents responded by enacting a gross receipts tax to fund an array of programs and services, with the promise of helping repair a broken and ineffective system of care.

Fast forward to today and, despite much forward progress, there are still too many individuals with mental illness cycling through the criminal justice system who are better served through targeted, coordinated programs in the community. Still today, too many individuals with unmet behavioral health needs continue to have frequent encounters with law enforcement and repeated incarcerations, consuming significant amounts of resources. What services exist remain predominantly in silos with communication and coordination between agencies and programs altogether stilted. Individuals with significant behavioral health issues continue to experience more frequent and longer lengths of incarceration.

In recent years, we have taken significant leaps forward, investing millions developing innovative, award-winning programs. But much work remains.

The following report represents a continuation of this community's commitment as memorialized in the 2015 Stepping Up resolution. In early 2018, the County, in partnership with the Criminal Justice Coordinating Council (CJCC), convened the "Diversion & Reentry Subcommittee" under the CJCC, setting a broad and diverse table for representatives from both criminal justice and behavioral health/service provider networks to engage and coordinate side-by-side.

More than thirty nine agencies and organizations participated over the spring and summer of 2019. Subject matter experts contributing to this report include individuals across state and local government, social services agencies, community-based providers, educational/vocational programs, criminal justice stakeholders, etc. (see Appendix A).

Detailed below is a set of broad recommendations, derived from participating experts on the subcommittee. Participants prioritized those recommendations agreed to be the most impactful in improving systems as a whole and specifically addressing the needs of the target population. The committee now moves ahead by forming a set of work groups that will focus efforts on achieving measurable progress on the leading recommendations in this report. In November 2019, the larger CJCC doubled-down on this approach by adopting its first strategic plan, which includes objectives mirroring both what is in this report and the original 2015 County resolution.

This report was made possible, in part, due to Bernalillo County's involvement in the 2018-20 cohort of Justice and Mental Health Collaboration Program (JMHCP) awardees, administered by the federal Bureau of Justice Assistance and with assistance from the Council of State Governments Justice Center. Also, critical facilitation and synthesis of information was provided by the UNM Echo Institute. A special thanks to all who've contributed countless hours and tireless attention to this important work and the development of this report.

Goals of the System Analysis

Residents, elected officials and community-based organizations throughout Bernalillo County want to improve services and outcomes for people with behavioral health (BH) issues who have been involved with the criminal justice (CJ) system and reduce their CJ involvement. The goals include improving the lives of these individuals and their families, improving public safety, and targeting resources appropriately.

> *"Arrest and incarceration often destabilize an individual's life, including their housing, health care, employment, and social connectedness. Researchers have found that even brief incarceration leads to… loss of employment… poorer physical and behavioral health… loss of housing… Once in the criminal justice system, individuals with mental and substance use disorders stay in jails longer, have an increased risk for self-harm, and receive more frequent punitive responses to infractions."*[1]

Population of Focus

The primary focus of this System Analysis is adults with BH issues—mental health (MH) issues or substance use disorders (SUD)—who have spent time in the Metropolitan Detention Center (MDC) and have a moderate or high risk of recidivism.

Funding

This System Analysis is funded by a federal grant awarded to Bernalillo County by the Bureau of Justice Assistance (BJA) through its Justice and Mental Health Collaboration Program (JMHCP). The County contracted with UNM's Project ECHO (ECHO) to carry out this Analysis in collaboration with the Criminal Justice Coordinating Council's (CJCC) Diversion and Reentry Subcommittee.

Objectives

The objectives of the System Analysis are to answer two questions:

- What's the current state? How do individuals flow through the current CJ system? This is addressed in the Current State section.
- What are the key opportunities for improving the system? Where are there gaps in services? This is addressed in the Recommendations section.

Definition: Diversion

Diversion refers to programs and practices that divert individuals out of the CJ system and into services and treatment. The goals are to achieve better outcomes for individuals without compromising public safety.

[1] Principles of Community-based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide. SAMHSA, 2019. Available at: https://store.samhsa.gov/system/files/sma19-5097.pdf.

Methods

The framework for this analysis—depicted in Figure 1—is based on the Sequential Intercept Model (SIM). We assessed how individuals with BH issues flow thru the CJ system at distinct "Intercepts;" how individuals are diverted from involvement with CJ; and how are they supported when reentering the community from jail. We also used the complementary approach of the Stepping Up Initiative, grouping programs and practices in terms of their potential to impact four key outcomes:

- Reducing the number of people with BH issues who are booked into jail;
- Reducing their lengths of stay in jail;
- Increasing their connections to community-based services;
- Reducing their recidivism; and
- Monitoring and evaluating BH/CJ system. (Not a key Stepping Up measure but considered an essential component.)

Creating this report has been an iterative process, requiring significant input from the CJCC Diversion and Reentry (D&R) Subcommittee and other stakeholders. The UNM ECHO team synthesized information gathered from one-on-one and small group interviews, CJCC D&R meetings, document reviews, and environmental scans of nationally-recognized, evidence-based programs and practices.

Definition: Reentry Services
Services that individuals receive in jail, before release, as well as RRC and community-based services following release. The transition from incarceration to the community is a critical period for ensuring continuity of care, reducing the likelihood of overdose or death after release, and linking individuals to needed social services and supports.

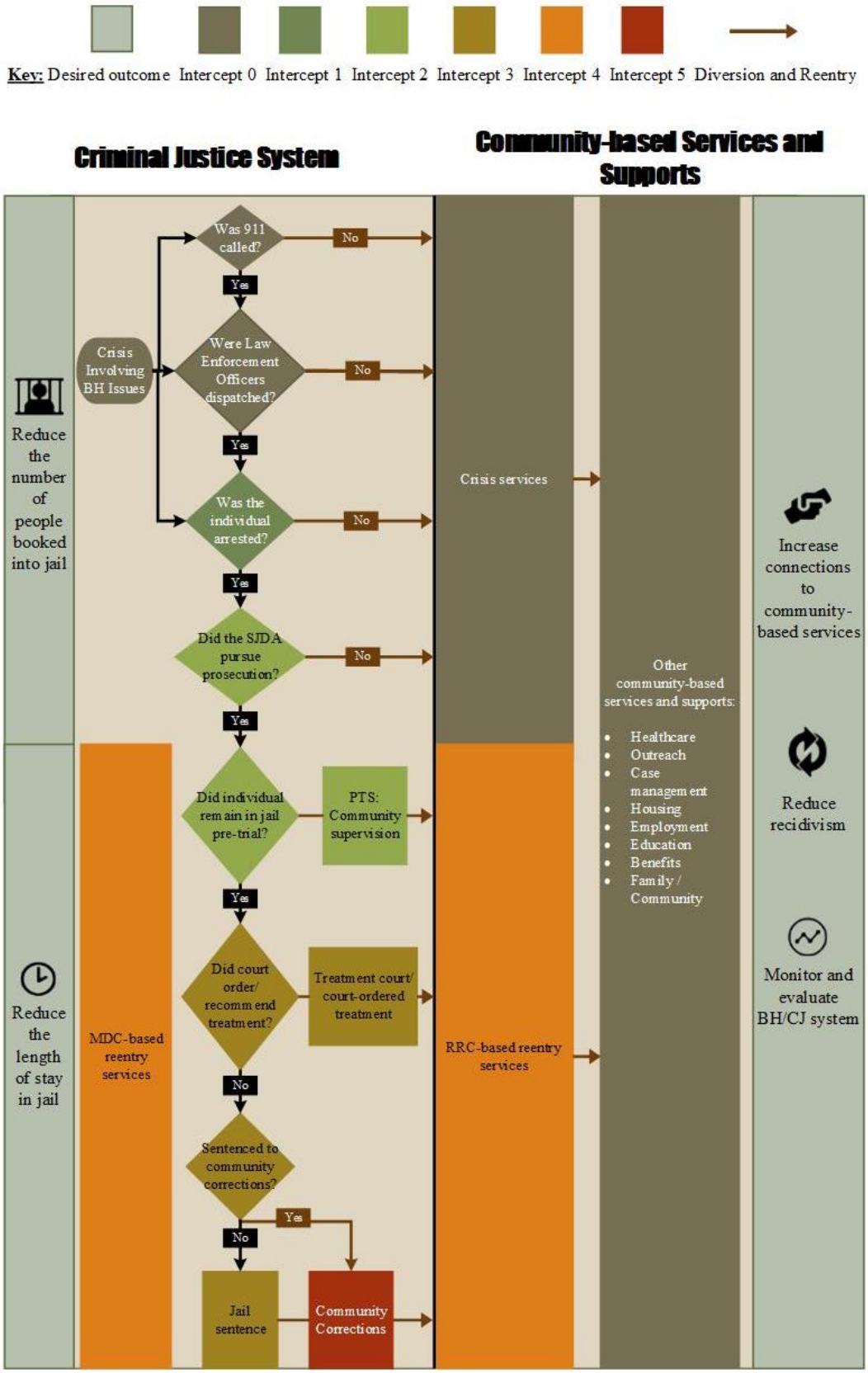
The topics of the CJCC D&R meetings during this System Analysis were:

- April 17: Introduction to the BJA grant and the framework for this System Analysis
- May 28: Crisis Services and Law Enforcement (Intercepts 0 & 1)
- June 25: The Court System (Intercepts 2 & 3),
- July 23: MDC and RRC-based Services (Intercepts 2-4)
- Aug 27: Prioritization of recommendations for Intercepts 0-4

Attendance at each meeting ranged from 35 to 39 participants. In total, 63 individuals from 34 organizations participated. See Appendix A. In preparation for these meetings, we conducted interviews with 26 organizations, speaking with 43 individuals. (Although we did not have a CJCC D&R meeting focused on Intercept 5—Community Corrections—we conducted two interviews and reviewed documents regarding this intercept.) See Appendix B. Throughout this document, we identify key national resources that may be beneficial and adaptable to our community; and, in Appendix C, we list key national resources to support future improvements to our local BH/CJ system.

Authors attempt to define acronyms before using them throughout this report. Acronyms for local organizations and programs can be found in Appendix D and a full glossary of acronyms is included in Appendix E.

Figure 1: Framework for System Analysis



Recommendations: Key Opportunities for Improving the System

The CJCC D&R meeting on August 27, 2019 focused on refining and prioritizing a set of recommendations that were derived from a number of one-on-one and group meetings occurring over the spring and summer of 2019. A summary of the results from this meeting and a brief guide to the 25 recommendations that are detailed below can be found in Appendix F. As shown below, a few recommendations stood out as being particularly high impact or low effort; or, at the other end of the spectrum, as particularly low impact or high effort.

Recommendations		Stepping Up Measures	Impact	Effort
12	Diversion involves two critical steps: exiting the CJ system and connecting to community-based services. Ensure that the latter step happens, especially for our most vulnerable residents (e.g., discharges from psychiatric emergency services).		High	Low
1	Now that we have a relatively a large selection of diversion and reentry interventions, shift resources towards improving existing interventions and improving collaboration and coordination across the overall BH/CJ system.		High	
6	Assess the extent to which the intensity of services provided matches individuals' risks and needs.		High	
11	Identify and support community-based organizations who wish to better serve their clients with BH issues and CJ involvement.		High(ish)	Low
9	Inadequate access to a continuum of community-based services contributes to a disproportionate number of people with BH issues in our jail. Continue to understand and address the most urgent unmet needs. Address both the perception and the reality that accessing BH services is easier inside the CJ system than outside the CJ system.		High	High
7	Use case conferencing to monitor and improve our BH/CJ system.		Low	High
15	Explore whether APD's Prisoner Transport Unit (PTU) could become a targeted site for diversion, leveraging the existing medical and BH screening of individuals at this intercept.		Low	High
10	Coalesce around a single online resource directory that can be tailored to individuals with CJ involvement and BH issues.		Low	
19	Monitor the impact of the new state rules regarding competency proceedings.		Low	

Developing Collaborative, Cross-Intercept Approaches

Broadly, four factors support our ability to develop a coherent BH/CJ system: First, community-based organizations have a long history of serving individuals with high needs, including those with CJ involvement and BH issues; and have developed formal and informal systems for collaborating and coordinating. It's worth noting that our BH system has had some major setbacks from which it is still recovering: In 2013, the State accused 15 nonprofit Core Service Agencies (about ¾ of the system) of

"egregious mismanagement," "fraud," and "corruption," and suspended reimbursement for services. Ultimately, the Attorney General cleared all 15 agencies (link).

As another supportive factor, we have BH infrastructure within MDC: clinicians provide treatment for MH issues—currently through Centurion—and for opioid use disorder (OUD), through Recovery Services of New Mexico; and we have intensive programing for SUDs through the County's Addiction Treatment Program.

A third factor is the CJCC and other CJ reform efforts, driven in part by the McClendon lawsuit and settlement and the City's settlement with US Department of Justice. A diverse group of CJ stakeholders have been convening for many years to proactively improve the CJ system.

Lastly, in 2014, voters approved a County gross receipts tax increase to pay for BH services, bringing in approximately $20M per year, adding to the City's comparable annual spending on BH services. This prompted the launch of the Behavioral Health Initiative (BHI), which the City and County jointly oversee.

The development a coherent BH/CJ system will require leveraging the expertise and resources across these four factors.

1. *Now that we have a relatively a large selection of diversion and reentry interventions, shift resources towards improving existing interventions and improving collaboration and coordination across the overall BH/CJ system.*
    a. Dedicate City/County/CJCC staff time towards improving collaboration and coordination and foster an engaged and representative CJCC D&R Subcommittee.

Ultimately, we hope the final list of recommendations will serve as roadmap for developing a coherent BH/CJ system. City, County, and CJCC leadership will need to clarify roles and responsibilities for moving forward with recommendations, staying up-to-date with the current state of our BH/CJ system, and continuing to identify emerging opportunities, including funding opportunities. It may also be beneficial to identify one or two leaders from our network of community-based organizations to serve on the CJCC and to chair the CJCC D&R. subcommittee This Subcommittee could directly pursue certain recommendations and advocate for and monitor the progress of others.

Related national models / initiatives: Stepping Up Strategy Lab: Representative planning team

b. Create an ombudsman-like role to allow agencies to share and resolve concerns.

"…changemakers must ensure that they pay sufficient attention to… power dynamics… Transforming a system is really about transforming the relationships between people who make up the system."[2]

In such a complex cross-sector, multi-agency environment like ours, tensions and challenging power dynamics are common. During the majority of interviews conducted by the ECHO team, interviewees brought up cross-agency tensions without prompting. Having a mechanism to constructively address these tensions may bring value.

[2] The Water of Systems Change.

c. Bridge knowledge gaps and cultural divides among stakeholders.

Interviews conducted by the ECHO team revealed a broad consensus around the goals of improving individuals' lives and improving public safety. However, interviewees also often perceived tension between these two goals, and expressed suspicion that some stakeholders valued one goal over the other. Targeted cross-training events, facilitated discussions, and other activities (such as case conferencing) that bring together small groups of diverse stakeholders could help build mutual respect and a shared understanding of the goals of our BH/CJ system. Cross-training events could leverage existing expertise, such as Albuquerque Police Department's (APD) experience leading crisis intervention trainings or UNM's experience leading trainings on Motivation Interviewing.

> Related national models / initiatives: Stepping Up Strategy Lab: Cross-training for probation, parole, and treatment providers

2. Continue to develop and improve (human and data) systems for collaboration and coordination.

> *Without coordination, BH and CJ professionals may work at "cross purposes, placing excessive, duplicative, or inconsistent demands on the most vulnerable and impaired individuals who are least capable of meeting those demands."*[3]

Individuals with BH issues and CJ involvement often come into contact with a wide array of providers, and face a heavy burden of screenings and assessments as well as a lack of coordination among providers.

a. Use local and national resources to build expertise about information sharing protocols that decrease client burden, improve continuity of care, and protect privacy.

Build off of local information-sharing successes, including the work of APD, RRC, and NMCEH. Inventory other local information sharing protocols, and develop and implement a plan to standardize and streamline approaches.

> Related national models / initiatives: PRA: Point-of-Service Information Sharing Between Criminal Justice and Behavioral Health Partners: Addressing Common Misconceptions; NEOMED: Sharing Confidential Mental Health and Addiction Information in Ohio: Mental Health and Addiction Providers and Law Enforcement

b. Adopt and tailor elements from the national Collaborative Comprehensive Case Planning model to our BH/CJ system.

This emerging national model (link) is based on the collaborative case conferencing used in the evidence-based Drug Court model, which we have experience with locally. For particularly high needs clients, it may be beneficial to assign a lead case planner when an individual is booked at MDC, who would reach out to other entities to form a case management team, and to conduct brief case conferencing until the client is clearly supported in the community. Which agencies provide the lead case planner and the case management team members could vary based on a number of factors including the individual's needs, length of stay in MDC, prior relationships with providers, etc.

[3] The Most Carefully Studied, Least Understood, Terms in the Criminal Justice Lexicon: Risk, Need, and Responsivity. SAMHSA's GAINS Center, 2018. Available at: https://www.prainc.com/risk-need-responsitivity/.

c. Develop protocols for coordination among providers who interact with clients at MDC.

Depending on the MDC unit and an individuals' needs, clients may come into contact with staff from up to eight different organizations; and all may provide some case management services. It may be challenging for clients to remember who they've spoken to about what; and there's no integrated system for tracking case management activities. Assigning a lead case planner, as discussed above, is one possible approach.

3. MDC and DBHS are in the process of selecting and implementing a new Jail Management System (JMS) and Client Management System (CMS). Develop a prioritized list of features for these new systems that could bring value to the BH/CJ system.

Features and approaches for the new JMS and CMS discussed during this System Analysis include:

- For the CMS, prioritize replacing the current SharePoint system that is used by RRC/MDC providers before implementing other components of the CMS.
- Create interfaces btw the CMS other data systems, including JMS, to create a one-stop shop for supporting clients with BH issues and CJ involvement. This may require inventorying current data systems, detailing who owns each and who has access to which data under what circumstances. See Appendix G for a preliminary list.
- Create an interface in CMS to Collaborative Comprehensive Case Planning (discussed above).
- Allow for different types of users (including both County and non-County staff), whose ability to read, write, and edit information varies depending on the information sharing protocols that are in place.
- Allow client-friendly Transition Plans and other tailored educational materials to be printed and shared with clients.
- Indicate which agencies, programs, and staff each client has a relationship with.
- Notify agencies and staff regarding key CJ events for their clients (e.g., MDC booking and releasing, court dates, conditions of release, etc.).

4. Work with key stakeholders at each Intercept to voluntarily and routinely submit measures regarding interactions with people with BH issues.

Across our BH/CJ system, many relevant measures are already tracked by individual organizations. However, currently there is no single entity, such as the CJCC, that gathers and shares that information, which could help to develop a shared, data-driven understanding of our CJ/BH system. SAMHSA recent guidelines—Data Collection Across the Sequential Intercept Model: Essential Measures—details relevant measures at each Intercept.

5. Develop and implement routine monitoring of the four Stepping Up measures (MDC bookings, length of stay at MDC, recidivism, connection to community-based services) for people with BH issues.

The CJCC has experience monitoring the first three measures for our overall jail population. (See below for more information.)

a. Develop agreement around key definitions

For example, do we monitor these four measures:

- by the Risk/Need Group that is based on the MDC Receiving Screening?
- for people with serious mental illness (SMI) and which definition of SMI do we use?
- for people with SUD?

  Related national models / initiatives: Stepping Up Strategy Lab: Shared definition of mental illness and serious mental illness, Shared definition of substance addiction

Another challenge will be to develop relevant and feasible definitions for connection to community-based services. One approach is to use a relatively simple measure, such as the number of non-emergency outpatient visits, using a data source such as Medicaid encounters or NM's Health Information Exchange (HIE). Overtime, we could also develop other measures, as well as associated data sources and data collection methods, such as:

Measures to assess connection to community-based service and supports	**Possible Data Sources**
Utilization of healthcare services—e.g., decreases in use of crisis/emergency services; increases in primary and BH care, prescriptions, medication treatment for OUD.	HIE, Medicaid, MATS, Department of Health, BHSDStar, Sapphire, NM Prescription Monitoring Program
Housing status	VI-SPDAT
Educational status	ABQ Public Schools, GED
Employment / life skills	NM Dept of Workforce Solutions
Use of case managers	UNM OCH Pathways Program, Intensive Case Manager Program, UNM Psych Forensics, ACT, Comprehensive Community Support Services
Wellbeing, health status, satisfaction with services	Standardized follow-up surveys (phone/mail) across diversion/reentry interventions to random sample of clients

Down the road, an important question that we may want our monitoring system to help answer is: Are there certain groups of individuals who are less likely to be connected to community-based services? Some programs have barriers to entry that may affect our ability to serve our highest need residents—for example, some are operating at capacity; some do not accept certain high need clients, such as those with prior violent behavior, borderline issues, sex offenses, or existing warrants; and some prohibit the use of medication treatment for SUD.

6. Assess the extent to which the intensity of services provided matches individuals' risks and needs.

Our BH/CJ system includes programs that vary widely by the intensity of services provided. For example, below we show various caseloads (per FTE) within our BH/CJ workforce:

- An MDC-based Social Services Coordinator carries a caseload of 150 to 225 people;
- MDC-based Transition Planner: 40-60 people;
- Pathways navigator: ~25 people;
- Fast Track and Law Enforcement Assisted Diversion (LEAD) case manager: ~20 people;
- Intensive Case Manager (ICM): 10-15 people;
- Assertive Community Treatment (ACT) team: ~10 people.

As another example, the MDC-based Addiction Treatment Program (ATP) is an intensive 4-week, team-based program that is operating at capacity due to court orders, with a 6-10 week wait to begin the program. High intensity programs such as ICM, ACT, and ATP are scarce and costly resources; a mature monitoring system could help ensure that these programs are targeted to our highest need residents.

7. Use case conferencing to monitor and improve our BH/CJ system.

In addition to quantitative monitoring reports, regularly discussing real (de-identified) cases that were particularly challenging or successful can also help to highlight system-wide gaps or opportunities. Case conferencing could happen in-person or via video teleconferencing; and could be incorporated into monthly CJCC D&R meetings. Cases in which stakeholders have differences of opinions can be especially good learning opportunities and help inform more challenging questions, such as: When is diversion appropriate? Inappropriate? Should diversion have been pursued earlier? What were the barriers to earlier diversion?

8. Identify key principals and evidence-base practices that are applicable across our BH/CJ system, assess their current application, and identify opportunities for expansion.

SAMHSA and the Council of State Government's Justice Center identify the following evidence-based or promising practices for people with BH issues and CJ involvement:

- Cognitive Behavioral Therapy (evidence-based for MH and SUD)
- Motivational Interviewing (for MH and SUD)
- Contingency Management Interventions (for SUD)
- Relapse Prevention Therapy (for SUD)
- Peer-based Recovery Supports (for MH and SUD)
- Pharmacotherapy (e.g., Medication-assisted Treatment) (for MH and SUD).

They also emphasize the need for:

- *Participant engagement* and a strength-based approach.
- *Gender considerations*.
- Recognizing and addressing issues that may contribute to *disparities* based on race, ethnicity, gender, sexual orientation, and economic status.
- *Trauma-informed* Services and workplaces.

Many local stakeholders have adopted some of the practices above. Information sharing and cross-training among stakeholders could help to increase adoption.

Community-based Supports and Services (Intercept 0)

9. Inadequate access to a continuum of community-based services contributes to a disproportionate number of people with BH issues in our jail. Continue to understand and address the most urgent unmet needs.

While several local and state-level reports describe deficiencies in our system for supporting people with BH issues, continuing to update our understanding of unmet needs remains important. The 2014 report Meeting Challenges: Finding Opportunities: Bernalillo County Behavioral Health Services Assessment states that "there is no question that the mental health system in New Mexico and Bernalillo County has

been underfunded and under-resourced for years." Like other reports, this one emphasizes that the issue is not the just the number and types of services available, but also the coordination among services. "Behavioral health services are fragmented… Communication between providers… is often uncoordinated and ineffective."

During this System Analysis, CJCC D&R participants identified a need for:

- More inpatient treatment beds for SUD and MH issues.
- Quicker access to community-based MH providers, including psychiatrists.
- More effective collaboration with HSD (State Medicaid Agency) and with Medicaid Managed Care Organizations (MCOs) to ensure that we are leveraging Medicaid benefits for the BH/CJ population as much as possible.
- More focus on the prevention, including UNM's First Episode Psychosis program.

  Related national models / initiatives: SAMHSA's three-part series regarding how the criminal justice system can play a role in shortening the duration of untreated psychosis. Vera Institute of Justice: First-Episode Psychosis: Considerations for the Criminal Justice System.

- More respite beds, including BH beds.
- Forensic ACT (FACT) teams. The County currently has three ACT teams (described below). (UNM ISR literature review regarding FACT teams)
- Implementation of a Supported Employment Model.
- Improved processes for obtaining identification, which is a pre-requisite for many services. (The County is working with the State to develop a pilot program that would allow individuals to obtain state ids using their MDC booking sheet, possibly at the RRC.)
- More transitional housing. Beds for released felons are restricted due to federal Housing and Urban Development (HUD) regulations.
- More permanent Supportive Housing options.

a. Address both the perception and the reality that accessing BH services is easier inside the CJ system than outside the CJ system.

The jail has many BH services that may be easier to access than comparable services in the community: Centurion provides MH services, Recovery Services of NM provides OUD treatment, and the County's Addiction Treatment Program. In addition, other parts of the CJ system (e.g., pretrial services, Specialty Courts, Probation & Parole) have special relationships (such as contracts) with community-based providers that may enhance access for those inside the CJ system.

10. Coalesce around a single online resource directory that can be tailored to individuals with CJ involvement and BH issues.

Currently, local Community Health Workers and others use the ABQ Coordinated Resource Guide and Share NM. The County has also mentioned developing an online directory of BH services; and the state's BH Collaborative runs the online Network of Care for BH. Notably, the latter is launching an OpenBeds Registry to track the real-time availability of beds for SUD and MH needs.

Related national models / initiatives: Stepping Up Strategy Lab: Community service directory.

11. Identify and support community-based organizations who wish to better serve their clients with BH issues and CJ involvement.

Many organizations serve this population (along with other populations), but lack knowledge about or relationships within the CJ system, hindering their ability to best serve these clients. The RRC has taken a lead in relationship-building via their quarterly meetings with community partners, proactive outreach, and RRC tours. There may be benefit in broadening and coordinating these efforts, including for example: educational materials, trainings, and tours regarding all intercepts; contact lists across all Intercepts; alert systems for knowing when clients have entered or exited the CJ system; etc. One group to prioritize are primary care providers, who can play a key role in integrating physical and BH care and connecting individuals to specialty care and other community-based supports and services.

> Related national models / initiatives: SAMHSA: Principles of Community-based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide; Stepping Up Strategy Lab: Jail notifies other agencies when a person is released

12. Diversion involves two critical steps: exiting the CJ system and connecting to community-based services. Ensure that the latter step happens, especially for our most vulnerable residents.

We have identified the release from jail as a particularly critical intercept and have invested resources in developing reentry programs, including the launch of the RRC and MDC-based Transition Planners. This improves the likelihood that people with BH issues who are being released from MDC will receive a warm handoff to community-based services. We also need to identify and address other critical junctures in which warm handoffs don't exist or need improvement, including for individuals:

- Whose charges are dismissed because they are found not competent to stand trial;
- Who are released from involuntary inpatient commitment or after a MH evaluation that did not lead to commitment; or
- Who are discharged from psychiatric emergency services.

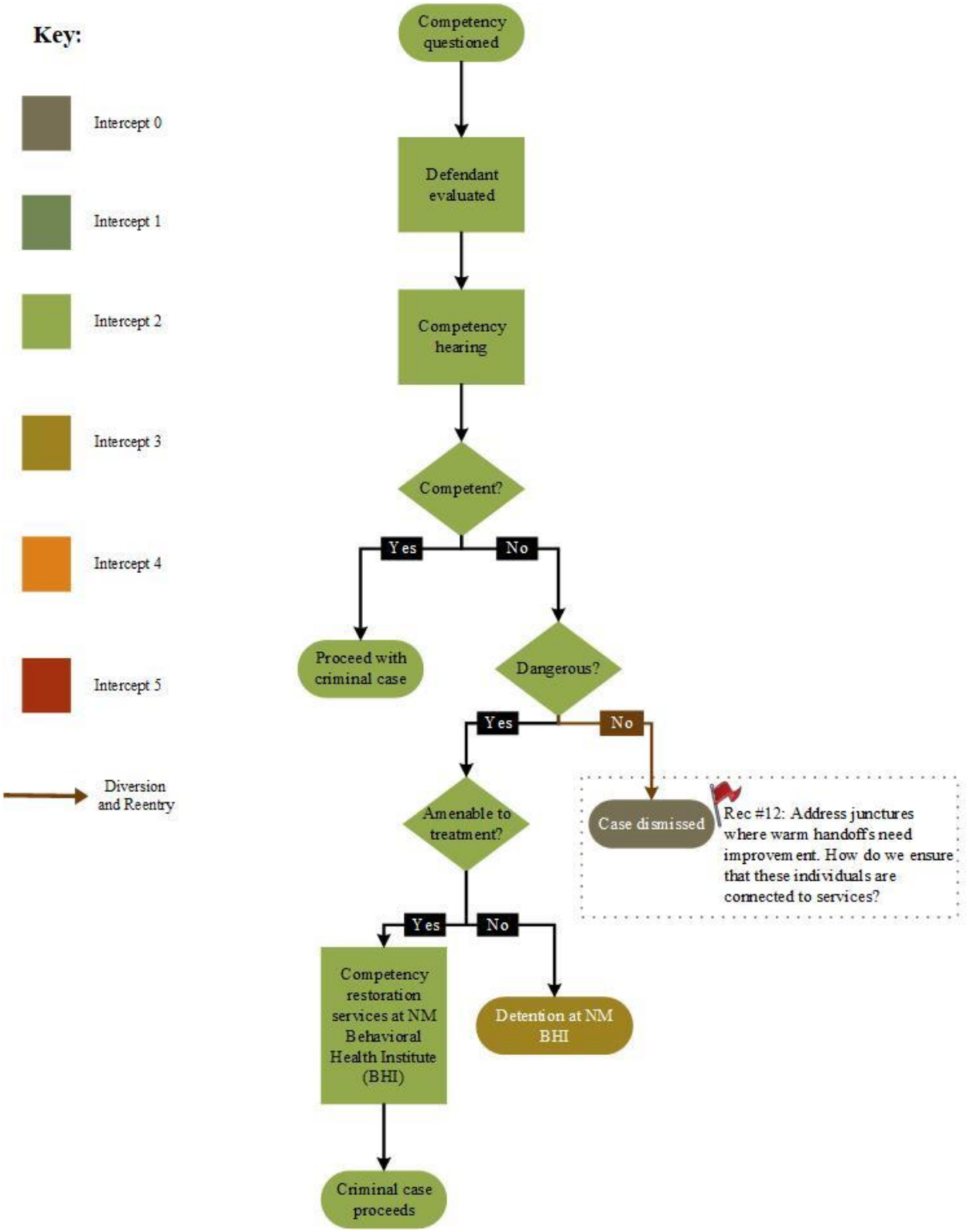
See Figures 2 and 3 for examples of the flow of individuals through our BH/CJ system that may lead to these critical junctures.

13. When diversion from the CJ system is appropriate, ensure that it happens as early as possible. Expand diversion options at Intercept 0.

In terms of how quickly individuals are connected to community-based services, the difference between early and later diversion can be days to weeks to years, given the how long it can take individuals to flow through the CJ system. The other benefit of early diversion is to minimize CJ involvement which has been shown to have negative outcomes for individuals.

The Treatment Advocacy Center in its 2017 "Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care" (p. 13) delineates the hierarchy of responses to a psychiatric crisis in this way: Default police response, Specialized police response, Collaborative police/MH response, and lastly MH-based response (without police involvement).

Figure 2: Sample flow for an individual when competency is questioned during a criminal case



a. Develop and pilot protocols for diverting appropriate calls from 911 to NMCAL. Explore other alternatives to calling 911 for families and individuals experiencing mental health crises.

Here is a sample protocol from Broome County, NY to guide their decisions about whether a 911 call should lead to dispatching law enforcement, or whether it's more appropriate to transfer to a BH crisis line. Protocols could also call for, for example, dispatching a Mobile Crisis Team, with or without law enforcement. The biggest area of concern is safety of BH clinicians who are dispatched to handle BH crises. We should build more expertise regarding how other communities implemented these approaches.

Explore whether families and individuals experiencing mental health crises could be better supported in avoiding unnecessary CJ involvement and ensuring appropriate access to care. This could include ensuring that residents are well informed of existing state laws regarding civil commitment and that processes are in place to support their use of these tools. State law, for example, allows families to "request the district attorney to investigate and determine whether reasonable grounds exist to commit the adult for a thirty-day period of evaluation and treatment" (NM Statute Annotated (NMSA) § 43-1-11), and more recent legislation allows families to petition SJDC to authorize assisted outpatient treatment (NMSA § 43-1b).

b. Pilot Mobile Crisis Teams that do not involve law enforcement.

Law Enforcement (Intercept 1)

14. Continue to expand LEAD and other early diversion back to Intercept 0.

Law enforcement officers have discretion regarding whether they arrest individuals or divert them to community-based services and supports; MATS and UNM PES are common diversion destinations. The recent launch of LEAD provides officers with another important diversion opportunity and with more assurance that individuals will be successfully connected to community-based services. As more officers are educated about LEAD and as the number of LEAD case managers increases, this has the potential to broadly shift practices at this early intercept.

Second Judicial District Attorney (SJDA) also has discretion regarding whether they pursue prosecution or divert individuals to community-based services and supports. Our new state law regarding assisted outpatient treatment (NMSA § 43-1b) provide another tool to the DA's office that, like LEAD, provides more assurance that individuals will be successfully connected to community-based services.

> *"Is a 'third way' of policing — deflection — emerging?... Police officers often only have a binary choice, arrest or release. Deflection seeks to use alternative remedies such as drug and alcohol treatment, hospitalization, and other diversionary programs, when appropriate, instead of introducing nonviolent, low-level offenders into the criminal justice system or releasing them back into the community without assistance."*

15. Explore whether APD's Prisoner Transport Unit (PTU) could become a targeted site for diversion, leveraging the existing medical and BH screening of individuals at this intercept.

When an arresting officer brings individuals to PTU for transport to MDC, they are first screened by a health professional to determine whether they require medical clearance before being booked. This screening provides additional information to assess whether diversion is a more appropriate path. Policies and procedures could be put into place that allow the screener and the arresting officer to share

information and collaboratively make a decision about diversion. Beginning in August 2019, rather than APD, Centurion will conduct these triage screenings at PTU, as they already do at MDC. (Centurion's triage screening at MDC is another intercept where the screener and arresting officer could share information and collaboratively make a decision about diversion prior to booking.)

It would be important to flesh out what happens after a diversion decision is made—e.g., do individuals go from PTU to the Reentry Resource Center? Do law enforcement officers transport home? Are they screened for LEAD and transported to MATS, if appropriate? While this recommendation has the potential to save resources for the overall BH/CJ system (by, for example, decreasing bookings at MDC), APD and Centurion would likely require additional resources to effectively carry out diversion at these intercepts.

16. Explore alternatives to current transport protocols for psychiatric evaluations.

Currently, when an individual experiences a MH crisis and requires a psychiatric evaluation, the protocol is for the individual to be handcuffed and transported in the patrol car to the hospital, which can be stigmatizing and traumatizing. Some communities call ambulances, which can be expensive and divert resources from life threatening emergencies. Other communities are exploring other alternatives (example from California and from Virginia).

> *"Commitment practices should respect the privacy and dignity of the individual. Every effort should be made to minimize trauma. If law enforcement agencies are responsible for transporting individuals proposed for or under order of commitment, they should assign plainclothes officers in unmarked cars, whenever possible. Shackles and other restraints should be used only if necessary, never as a matter of routine."*[4]

The Court System (Intercepts 2 and 3)

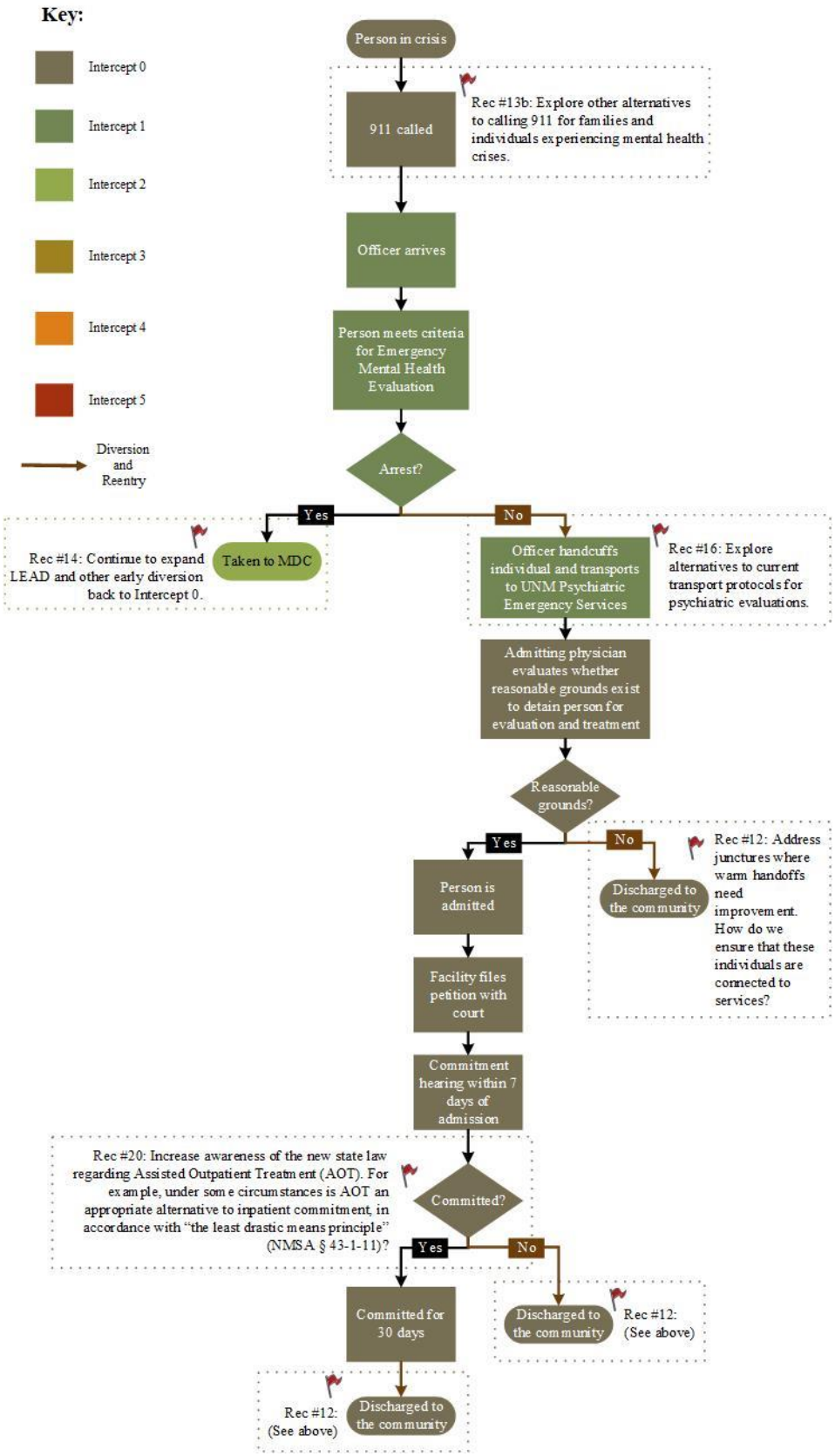
17. Periodically convene stakeholder meetings focused on continuing to improve our Specialty Courts.

Locally and nationally, the Specialty Court model has continued to evolve as we gather more evidence about what's most effective. For example, there's a movement toward being less punitive and more therapeutic and towards integrating medication treatment for SUD. In addition, Metro and SJDC have a large number of Specialty Courts that are targeted towards different populations, with different goals, and different policies and practices.

Periodic stakeholder meetings could help ensure that community-based organizations are well informed about the options and have the opportunity to provide input regarding gaps and opportunities for improvement. Interviews during this System Analysis indicated that some organizations advise their clients to avoid certain Specialty Court because of the perception that the requirements are too onerous. Periodic meetings would also give team members across diverse Specialty Courts the opportunity to discuss best practices and lessons learned—e.g., regarding how to maintain consistency among team members, which improves the Court's knowledge base, buy-in, and referrals.

[4] Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice. SAMHSA, 2019. Available at: https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf.

Figure 3: Sample flow for an individual facing a BH crisis



18. Continue to adopt evidence-based practices within Metro and SJDC pretrial services (PTS), and improve continuity between Metro and SJDC PTS.

See below for a description of the Current State of PTS and see Figure 4 for the roles that Metro and SJDC PTS play in a typical felony case.

19. Monitor the impact of the new state rules regarding competency proceedings.

A 2013 report from the NM Sentencing Commission found that the median length of stay for arrestees with a competency proceeding was 278% longer than for those without a competency proceeding, even after controlling for whether the charge was a misdemeanor or felony. This issue was echoed by several stakeholders during this System Analysis. The NM Supreme Court approved new rules regarding competency proceeding earlier this year that limited the scope of a competency evaluation, formalized and streamlined processes, required the appointment of a neutral evaluator, and imposed time limits. CJCC D&R participants noted that the main issue on the felony side is availability of evaluators. SJDC is a launching pilot program and hiring forensic staff to conduct evaluations; hope to see results within 2-3 months.

20. Reach broader agreement about whether, when and how to use involuntary civil commitment. Increase awareness and understanding of the new state law regarding Assisted Outpatient Treatment (AOT).

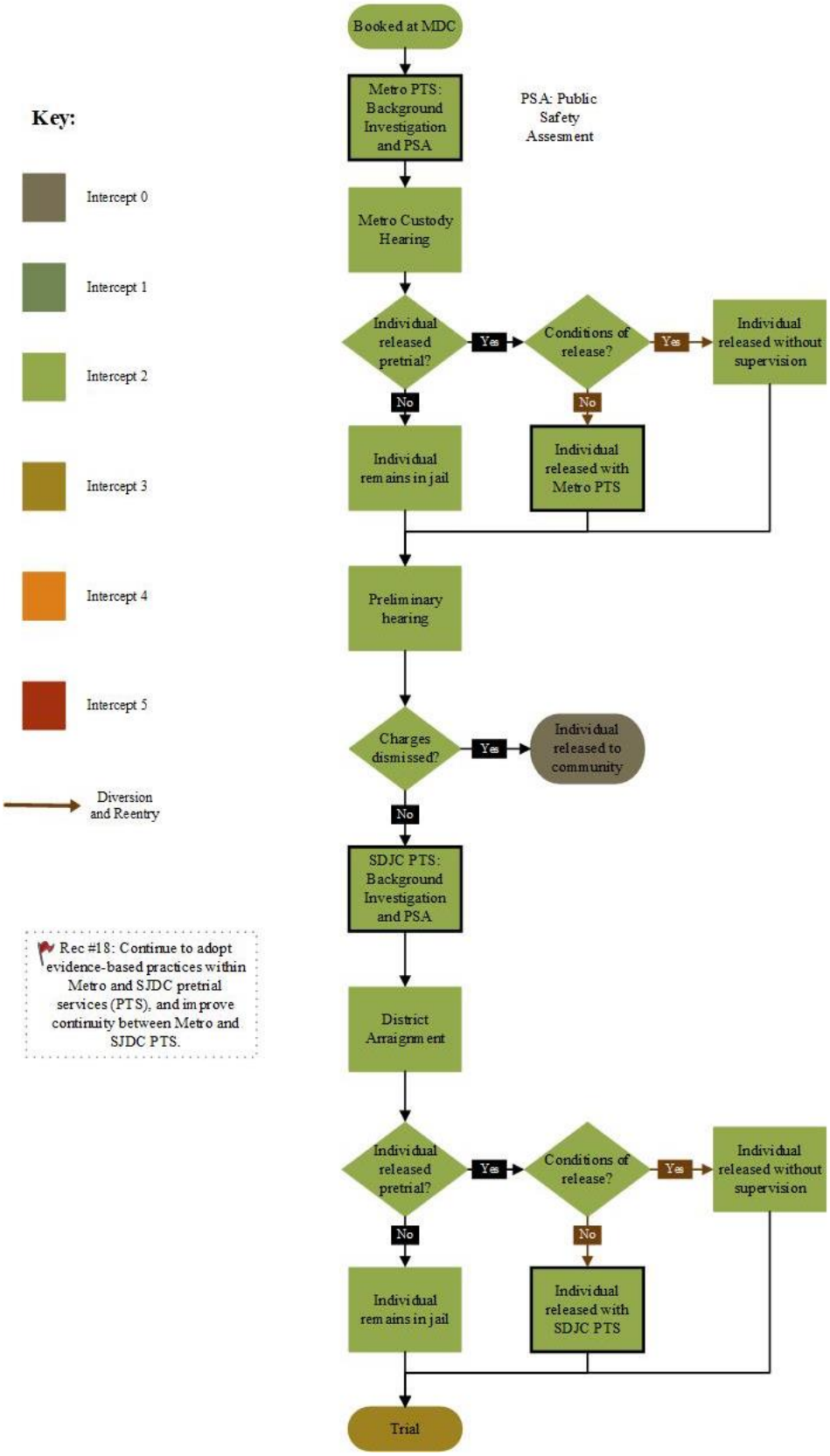
Some stakeholders believe that civil commitment is rarely, if ever, appropriate. It "involves a significant limitation of liberty… that is rare outside of the CJ system."[5] On the other hand, others believe that that this tool is underutilized, setting individuals up for failure and for repeated incarcerations. In addition, the new AOT law—i.e., *outpatient* civil commitment—significantly changes how civil commitment can be used locally.

When statutory criteria are met, AOT can be used as a step-down from inpatient civil commitment and from MDC-based psychiatric services. Notably, AOT may also be an appropriate *alternative* to inpatient civil commitment or an alternative to prosecution or jail in some scenarios. (Inpatient civil commitment may also be an appropriate alternative to prosecution or jail in some cases.)

> Related national models / initiatives: National Institute of Justice gives AOT its highest rating of "Effective - More than one study" and the American Psychiatric Association has issued a detailed policy statement on AOT, including "[AOT], if systematically implemented and resourced, can be a useful tool to promote recovery."

[5] Ibid.

Figure 4: Roles that Metro and SJDC PTS play in a typical felony case



MDC and RRC-based Reentry Services (Intercepts 2-4)

21. Continue to expand and improve boundary-spanning activities.

The federal BJA grant provides funding for boundary-spanning navigators who will first connect with individuals in MDC, then continue to work with them in the RRC and the community. Other current examples of "boundary spanning" include: having Transition Planners in both MDC and RRC; having the RRC-based CHWs continue to support clients in the community; Pathways navigators working with clients in both the RRC and the community, and Fast Track case managers working with clients in all three locations (MDC, RRC, and community).

A possible downside of in-reach into MDC or RRC by community-based organizations is that it could introduce more players into an already complex system; a possible upside is that this boundary-spanning can provide more continuity, allowing the client to have contact with a single entity in all three settings: MDC, RRC, and the community. There are different viewpoints regarding to what extent and in what manner in-reach should happen; and whether in-reach should focus on MDC, RRC, or both.

> Related national models / initiatives: Stepping Up Strategy Lab: Jail in-reach by community-based services

22. Cross-training and relationship building between reentry service providers and MDC leadership and correctional officers may help improve reentry services.

MDC leadership and correctional staff play critical roles in supporting successful reentry. More effort may need to be invested in developing buy-in and in integrating correctional staff into the reentry system. Issues that have been raised during the System Analysis include:

- Transition Planners face barriers in accessing individuals during their first court appearance.
- The length of time that it takes to release some individuals from MDC leads to many off-hour transports from MDC to RRC, which make connections to community-based services more difficult.
- Reducing the length of stay for individuals with BH issues is especially challenging because of medical/psychiatric holds, which can add anywhere from 6 to 24 hours past a court-ordered release.
- During off-hours, people may be released without all their property, in particular, without access to their cash.

23. Continue to increase outreach and marketing to ensure that individuals with BH issues and CJ involvement—and community-based organizations that serve these individuals—are aware of MDC- and RRC-based reentry services.

24. Address barriers that patients face in receiving timely, effective treatment for opioid use disorder in MDC and when they transition back to the community.

In MDC, Recovery Services of New Mexico (RSNM) administers methadone to treat OUD. Initially, only maintenance treatment was provided; however, recently RSNM began providing induction services. Currently, neither RSNM or Centurion offer other evidence-based treatments for OUD (buprenorphine

or naltrexone). The County's Addiction Treatment Advisory Board helped advocate for adding methadone induction, and continues to advocate for the addition of buprenorphine.

Related national models / initiatives: SAMHSA: Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings

a. Address barriers to receiving timely methadone treatment in MDC.

Clinics that provide methadone treatment for OUD are under significant state[6] and federal regulations. At MDC, RSNM typically cannot begin maintenance treatment without certain paperwork from the current community-based provider, which can take anywhere from minutes to days. Explore whether SOTA can either put additional requirements on community-based providers or loosen requirement on RSNM to facilitate continuity of care for individuals entering MDC.

When released from MDC, a significant barrier to continuing methadone treatment in the community is the lack of identification. Many clients receiving methadone at MDC are homeless and without income or the necessary documentation to obtain an identification. Many community-based clinics require identification, although some accept jail bands as identification. Again, explore whether SOTA can support policies that promote improved transitions back to the community.

b. Accelerate the introduction of buprenorphine as a treatment option for OUD in MDC.

The regulations regarding buprenorphine are fewer than with methadone; and the introduction of this treatment option in MDC could address some of the barriers faced with methadone. In the community, many patients choose buprenorphine over methadone for a variety of reasons (e.g., the stigma associated with receiving methadone at an Opioid Treatment Program vs. receiving buprenorphine from a primary care provider). Currently, individuals receiving buprenorphine in the community must detox from this medication when they are booked at MDC, disrupting continuity of care for a serious chronic condition.

c. Ensure that medication treatment for OUD is fully integrated into our BH/CJ system.

Build stronger relationships between our various diversion and reentry initiatives—e.g., APD/CIT, LEAD, Mobile Crisis Teams, Specialty Courts—and our various specialty and primary care providers with OUD treatment programs. Develop "low-threshold" access to buprenorphine to enhance continuity of care for individuals transitioning in or out of MDC.[7]

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[6] The state's Behavioral Health Services Division (BHSD), under HSD, is the State Opioid Treatment Authority (SOTA) which regulates our Opioid Treatment Programs (OTPs) which provide methadone treatment for opioid use disorder. BHSD is also the federal "Single State Agency for Substance Abuse Services" for SAMHSA and other funding.

[7] Expanding low-threshold buprenorphine to justice-involved individuals through mobile treatment: Addressing a critical care gap, 2019. Available at: https://www.journalofsubstanceabusetreatment.com/article/S0740-5472(18)30446-X/pdf.

Community Corrections (Intercept 5)

25. Advocate for HB 564 during next legislative session. Work with stakeholders to build support and to address outstanding concerns regarding this bill to strengthen probation and parole supervision practices.

At the request of state leaders, NM began working with the Justice Reinvestment Initiative—and receiving technical assistance from The Council of State Governments (CSG) Justice Center—in the Summer of 2018. CSG's final report regarding NM was released in August 2019. Among other things, the report includes, policy recommendations to strengthen probation and parole supervision practices; it also details why the governor vetoed HB 564 during the prior legislative session even though it passed out of both the Senate and the House with significant majorities.

> Related national models / initiatives: CSG: A Ten-Step Guide to Transforming Probation Departments to Reduce Recidivism

Some of the key provisions of HB 564 include: (From CSG's final report regarding NM)

- "**Require the NMCD [Correction Department], parole board, and judiciary to follow best practices**. NMCD is poised to transform its supervision practices and would benefit from a legislative mandate to abide by the principles of effective intervention, such as focusing resources on people with the highest risk of reoffending and targeting criminogenic needs… require judges and parole board members… to consult risk and needs assessment results when setting supervision conditions… require [NMCD's] presentencing reports to include the results of these assessments…
- **Require the NMCD to validate its risk assessment tool [COMPAS]**…
- **Equip probation and parole officers with appropriate training**… such as effective case planning, motivational interviewing, and reinforcement of cognitive behavioral techniques…
- **Require the NMCD to develop a consistent incentives and sanctions system**… NMCD must respond to technical violations… with less costly and more effective sanctions… require the NMCD to build upon the STEPS program to establish a consistent incentive and sanctions model across the entire state and educate judges and the parole board on the use of the program. Research has shown that positive reinforcements and incentives can help improve engagement and reduce recidivism as much as or more than a sanction-only approach and can limit the need for costly punitive sanctions…
- **Provide information and training about the incentives and sanctions system**… to judges, the parole board, district attorneys, and other stakeholders… to encourage support for the improvement of supervision practices…
- **Allow judges to [continue to] hold hearings for technical violations… but encourage them to permit probation and parole officers to administer limited sanctions in accordance with the sanctions and incentives matrix**…"

Current State: Our System for Serving People with BH Issues and CJ Involvement

We use the Stepping Up icons (defined on page 3) to specify which measures the programs and practices described below relate to. (We don't label any programs or practices as directly related to reducing recidivism, as this results from the effect of the prior measures.)

Cross-intercept Practices

Data, monitoring, and research infrastructure

Our capacity in this area includes:

- The County's long-standing relationship with UNM's Institute for Social Research, which has been supporting the County and the CJCC with data analysis and evaluation for years; and has been involve with BHI since its inception.
- The County's ongoing participation with the national Data-Driven Justice Initiative; and the potential to expand this effort through funding both from the state and from Arnold Ventures. During the 2019 legislative session in NM, the governor signed HB 267, which provided funding for data integration. The CJCC submitted its data integration proposal to the NM Sentencing Commission in August; funding could begin as early as September.
- The new Jail Management System (JMS) and Client Management System (CMS) that are in development.

In addition, the CJCC has a long history of monitoring key CJ measures. As demonstrated in Figure 5 below, from the CJCC's November report, proactive monitoring can contribute to a better understanding of the impact of different initiatives.

Definitions of key terms that are currently in use

As discuss above, in order to implement routine monitoring of our BH/CJ system, we need to build agreement around key definitions.

Recidivism

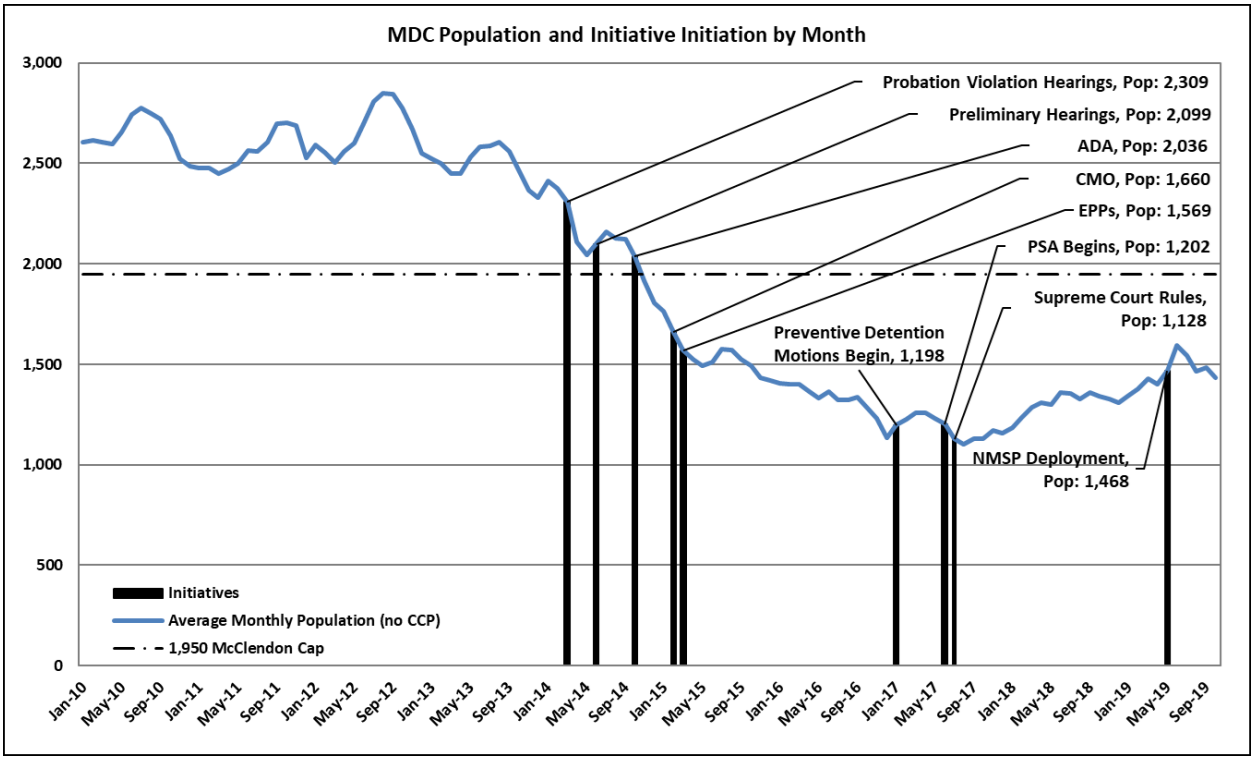
Broadly, recidivism means relapsing into the CJ system, typically after leaving jail or prison. As the NM Sentencing Commission points out, there are many ways to measure recidivism, and each requires specifying the starting point, ending point, and duration. For example, the CJCC reported the percentage of individuals who were re-booked at MDC (ending point) within one year (duration) of their MDC booking (starting point). (Within 1 year of an MDC booking, almost half of individuals were booked again.) As another example, our local adult (non-DWI) Specialty Courts define recidivism as the percentage of individuals with a felony arrest within 3 years of exiting the Special Court.

BH Issues

When discussing an individual's BH needs, we need to distinguish between screening for a need, further assessing a need, or determining a diagnosis. The MDC Risk/Need Group (described below), which is based on the MDC Receiving Screening, indicates whether individuals screened for MH issues or for SUD. The state's BH Collaborative lists the specific SMI and SUD diagnosis codes that determine whether individuals are eligible for certain publically-funded BH services (in additional to additional criteria, such

as age and functional impairment). The County is determining how these state's SMI and SUD definitions align with the MDC's medical contractor, Centurion.

Figure 5: From CJCC's November report, depicting ongoing monitoring of MDC population



CJ Involvement

We currently have at least three processes for assessing individuals' CJ involvement: First, the MDC Risk/Need Group (described below) which is based on self-report. Second, assessing criminogenic risk is also built into our court system, via the evidence-based Public Safety Assessment. The primary use of this tool is to assist judges during custody hearings, when they decide whether a defendant should be released while awaiting trial. Lastly, the County pulls data from their Client Management System and other sources to identify "high utilizers." Their definition is based on individuals' use of County SUD programs, Emergency Department visits, and inpatient hospitalizations; and on MDC bookings.

Community-based Supports and Services (Intercept 0)

Crisis lines

New Mexico Crisis and Access Line (NMCAL) (link): A 24-hour hotline to support those experiencing BH crisis. The hotline is staffed by professional counselors who offer immediate assistance, as well as make referrals to services on a case-by-case basis. They also have a Peer-to-Peer warmline for those who would rather talk to a Peer Support Worker. People also sometimes call the **NM Poison and Drug Information Center** (link) for drug overdoses.

Related national models / initiatives: Stepping Up Strategy Lab: Crisis lines.

Emergency Services / Crisis stabilization. These are key examples of programs that law enforcement officers can use to divert individuals experiencing a BH crisis away from the CJ system.

UNM Psychiatric Emergency Services (PES)

DBHS/MATS/Crisis Triage and Stabilization Center: DBHS and UNM are collaborating to expand services. UNM recently took over administration of the Medical Observation and Treatment Unit. A 16-bed crisis stabilization unit will open soon, and, later, an outpatient clinic for those pre- and post-crisis.

Related national models / initiatives: Stepping Up Strategy Lab: Crisis stabilization centers.

DBHS/MATS/Public Inebriate Intervention Program (PIIP): Designed to relieve congestion in local Emergency Departments and to reduce bookings at MDC by providing stabilization, observation and placement support services. Clients can stay for up to 24 hours or, if they choose to participate in the Detox Program, for up to 3 days.

DBHS/MATS/Detox Program: Serves clients detoxing from alcohol, opiates, and methamphetamines. Clients can stay up to 10 days in one of the 48 beds available. Most clients utilize the services for only 3 days, and if they choose to stay longer they are required to attend group meetings. Upon completion of the program, clients may qualify for the MATS 30-week, low-intensity residential program, Supportive Aftercare Community.

Home-based pre/post crisis support. These programs are based on the COAST model (described below), but do not include law enforcement.

CABQ / AFR / Home Engagement and Alternative Response Team (HEART) (link)

NM Hope (link). Received BHI-funding for Community Engagement Teams (CET).

High intensity services

Heading Home / ABQ Street Connect (link)**:** Provides intensive, housing-focused service navigation to individuals experiencing chronic homelessness and BH challenges who are the highest utilizers of emergency services. They have begun co-locating a Navigator at UNM PES to support clients during and after crisis.

Assertive Community Treatment (ACT) (link): ACT is a multidisciplinary team approach and evidence-based practice that improves outcomes for people with SMI who are most at-risk of psychiatric crisis, hospitalization, and involvement in the CJ system. It's one of the oldest and most widely researched evidence-based practices for people with SMI. Three local organizations have ACT teams: **HopeWorks, UNM Psychiatric Center, NM Solutions**.

UNM CHWI / Intensive Case Manager (ICM) Program: Focused on people with SUD who are high utilizers of emergency services or CJ system. Program includes 8 ICMs based out of 7 sites (including the RRC), plus two supervisors. Clients can stay on as long as needed; they collaboratively set goals with ICM, which are re-evaluated every 3 months.

Other community-based supports and services

See Appendix D for a partial list of other organizations and programs that provide community-based supports and services, including housing, education, benefits, outreach, case management, primary care organizations with integrated BH health, etc.

Law Enforcement (Intercept 1)

APD / Crisis Intervention Section (CIS) (link)**:** APD's diversion programs operate under CIS, which has been around since 1988, but was revamped under CASA—the DOJ Court-Approved Settlement Agreement. All 911 operators, dispatchers, and officers received BH/crisis training (link). They have also developed the CIT ECHO to provide ongoing education using weekly videoconferences to conduct extended case debriefings of encounters between police and people with mental illnesses. CIS staff include a two BH clinicians, who are supervised by the BH Division Medical Director, a psychiatrist (link).

APD has 6 detectives with enhanced CIT training and 2 APD clinicians who respond to high-risk calls when individuals with BH issues may be putting others at risk. A team (detective + clinician) is sent out once reasonable safety can be assured. They also keep tabs on high utilizers, following up twice a month to support these clients and decrease need for 911 calls.

> Related national models / initiatives: Stepping Up Strategy Lab: Specialized law enforcement team, Crisis Intervention Team (CIT), Mental health professional embedded in law enforcement agency

APD CIS / Crisis Outreach and Support Team (COAST) (link)**:** This program pairs an officer with an APD civilian social worker/counselor in 5 of the 6 Area Commands. It is designed to support people in low-level crises, along with the officers who respond to those cases. They work nonviolent cases, and the civilian counselor connects people to services.

> Related national models / initiatives: Stepping Up Strategy Lab: Homeless outreach teams.

Mobile Crisis Teams (MCTs) (link)**:** APD has 4 MCTs and Bernalillo County Sheriff's Office (BCSO) has 2 teams. Each team consists of an officer and a masters-level BH clinician from HopeWorks, who work together in a patrol car on 10-hour shifts. A team can be dispatched from a 911 call or from officers in the field. They respond to the scene to deescalate, assist the individual in crisis, and provide resources. HopeWorks clinicians have broader authority than officers to write a certificate of evaluation for an involuntary commitment. At the same time, they can help avoid unnecessary involuntary commitments. HopeWorks is also able to plug clients into a continuum of care and can be part of the discharge plan when individuals are taken to the hospital.

> Related national models / initiatives: Stepping Up Strategy Lab: Co-responder team

Law Enforcement Assisted Diversion (link)**:** APD and BCSO are participating, in collaboration with DBHS/MATS, who is providing case managers. When individuals commit a low-level drug-related crime, they are given the opportunity to voluntarily participate. They are transported to DBHS/MATS, where they complete an intake and assessment, at which point, the charges against the individual can be dropped with SJDA's approval. The case manager collaboratively develops a plan with the individual and s/he can remain in the program as long as needed. DBHS expects to expand to 4-6 case manager, each with caseloads of about 20 individuals.

The Court System (Intercepts 2 and 3)

Two court systems handle criminal (as well as civil) cases in Bernalillo County: Metro Court, which handles misdemeanors, felony first appearances, DUI and other traffic violations, domestic violence and

DWI cases; and the Second Judicial District Court (SJDC), which has general jurisdiction. Other key players at these intercepts include the Law Offices of the Public Defender (LOPD) and Second Judicial District Attorney (SJDA).

Early Release ROR (release on one's own recognizance) Program

When individuals are booked at MDC, they can be ROR'd without going before a judge if they meet certain criteria. This program is run 24/7 by Metro Court using video teleconferencing. It applies to open-charge misdemeanors and 3rd and 4th degree non-violent felonies, and may include conditions of release.

Pretrial services

Both Metro and SJDC provide pretrial services (PTS). The NM State Bar recently recognized SJDC's Judicial Supervision and Diversion Program—which provides PTS—as its "Outstanding Program" for 2019 for its "use of nationally recognized, evidence-based methods for establishing public safety risk and appropriate supervision and oversight for defendants awaiting trial." SJDC's practices are guided by the National Institute of Corrections (NIC). (See, for example, NIC's A Framework for Pretrial Justice: Essential Elements of an Effective Pretrial System and Agency and Measuring What Matters: Outcome and Performance Measures for the Pretrial Services Field.) Examples of evidence-based practices that are in use include:

- Both Metro and SJDC use the national Public Safety Assessment (PSA) (link) to guide judge's pretrial release decisions.
- SJDC uses an evidence-based decision matrix to determine an appropriate pretrial monitoring level, based on the results of the PSA, which assesses risks for Failure to Appear (at trial) and New Criminal Activity (sample matrix).
- SJDC is beginning to monitor nationally-recognized outcome and performance measures, such as:
    - Appearance Rate: % of individuals who make all court appearances.
    - Safety Rate: % of individuals not charged with a new offense during pretrial.
    - Recommendation Rate: % of time risk assessment criteria are followed when deciding to release or detention.

Specialty Courts

Both Metro and SJDC run a variety of Specialty Courts (also known as Treatment Courts or Problem-Solving Courts). Most of the Specialty Courts target repeat offenders whose criminal activity is driven by underlying BH issues; they integrate BH treatment services with case processing; and they must follow the NM Drug Court Standards, which are based on national standards.

These diversionary programs typically last a year and can be either pre-adjudication or post-adjudication (or both). The former means the individual is diverted into the Specialty Court prior to pleading to a charge, and if they complete the program, they will not be prosecuted. With post-adjudication programs, defendants typically plead guilty to their charges but their sentences are deferred or suspended while they participate in the program; and successful completion will influence sentencing

and can result in a waived sentence or an expungement of the offense. Specialty Courts use a team-based approach, typically including the judge, prosecuting and defense attorneys, treatment provider, case manager, and probation/PTS. Enrollment in Specialty Court typically requires agreement from both LOPD and SJDA.

> Related national models / initiatives: CSG Justice Center: Mental Health Courts: A Primer for Policymakers and Practitioners

SJDC Specialty Courts include:

- Young Adult Court is a new program that serves those ages 18 to 24 with SUD. It relies on recent research pointing to the need for specialized strategies targeted to this age group. It can be either pre- or post-adjudication and may result in no conviction on the client's record. It had 22 client as of March 2019.
- Felony Repeat Offender DWI Court. It has had 35 individuals graduate since its 2013 inception with a 0% recidivism among them.
- Mental Health Court. While it follows the same principles as the Drug Court model, MH Court offers more assistance to clients, monitors compliance, and does more warm handoffs to community agencies. There were 30 clients in the program as of March 2019.
- Adult Felony Drug Court. This specialty court is funded and run by NMCD, and includes both pre- and post-adjudication options. Historically, this court was abstinence-based, but during the last two years it has included a track for medication treatment for SUD.
- Healing to Wellness Court is a track within the Adult Felony Drug Court that incorporates holistic healing strategies into its treatment programs.

Metro Specialty Courts include:

- Behavioral Health Court is focused on individuals with MH issues and is pre-adjudication. Enrollment is voluntary, and this court applies only to misdemeanor crimes and usually first-time offenders. Because of its focus on MH, this court is more individualized than typical drug courts. It is supported by a federal grant.
- Substance Use and Treatment Options Program (STOP) serves offenders who have been charged with a non-violent, felony, substance-use related crime in Bernalillo County, which has been pled down to a misdemeanor.
- Outreach Court. Follows the American Bar Association's guidelines for Homeless Courts (not the Drug Court model). It is targeted to individuals with limited means of complying with conditions of the court, and enables them to address outstanding legal obligations. Prospective participants are referred by community-based treatment providers, and continue to work with these providers in order to satisfy the courts' requirements.

For more background, see the Legislative Finance Committee's most recent evaluation of NM Drug Courts.

SJDC's Probation Violation Program

In 2014, a felony Probation Violation Program (PVP) was implemented in SJDC that has shortened the amount of time that people with probation violations spend in MDC. While most who are booked at MDC appear before a judge within 24-48 hours for a custody hearing, this is not the case for people who return to MDC due to a probation violation. On a given day, about one-quarter of people at MDC have a felony probation violation as their highest charge.

Under PVP, the scheduling of PV hearings was changed from 30 days from the filing of the motion to revoke probation to 20 days from arrest. This helped to reduce the time to the judge's disposition from about 30 days to about 20, although this case processing time has been trending up during the last couple years.

Competency to stand trial

Competency proceedings are governed by NMSA § 31-9; and, as mentioned, the NM Supreme Court also approved new rules earlier this year. Generally, when a defendant's competency to proceed in a criminal case is questioned, case proceedings are suspended. A qualified professional then evaluates the defendant and sends the court a report; the court then holds a hearing to determine competency. If the defendant is found incompetent, the court then determines whether the defendant is dangerous. If there is no finding of dangerousness, the case is typically dismissed. The SJDA may then seek involuntary inpatient commitment or make a referral to AOT, the new outpatient commitment option. Metro runs a Competency Court that is designed move defendants who raise competency concerns through the court system efficiently.

Involuntary civil commitment

Commitment proceedings are governed by NMSA § 43; this includes the long-standing "Mental Health and Developmental Disabilities Code" (Article 1), as well as the relatively new "Assisted Outpatient Treatment (AOT) Act" (Article 1b). Under certain circumstances, either inpatient or outpatient commitment can be used to divert individuals from prosecution or jail. In addition, the new AOT option may also create some scenarios in which outpatient commitment can be used to divert individuals from inpatient commitment.

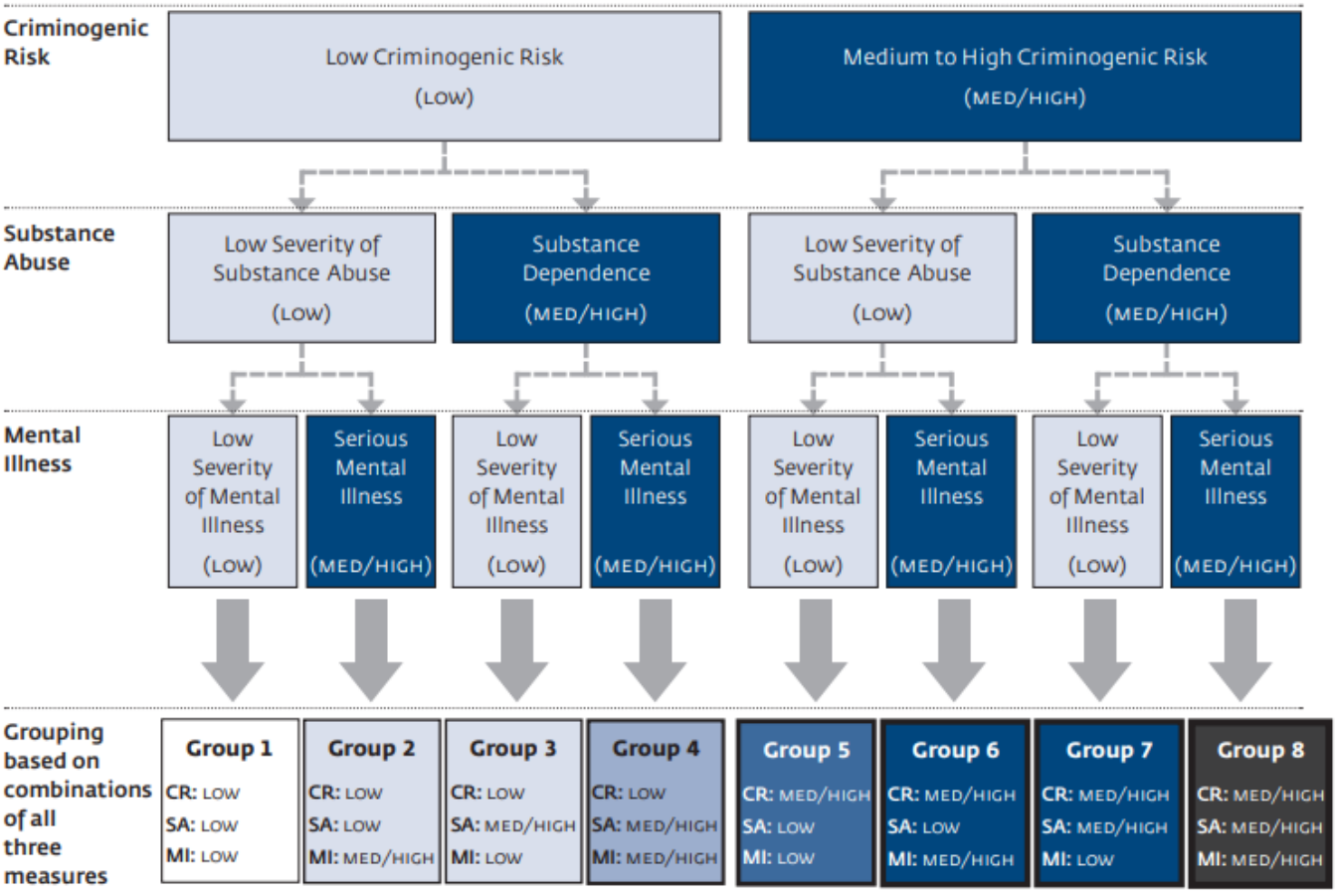
MDC and RRC-based Reentry Services (Intercepts 2-4)

MDC Receiving Screening and Risk/Need Group

Centurion, the medical contractor at MDC, conducts a screening of everybody who is booked at MDC. Part of this screening includes an assessment of Criminogenic Risks and Behavioral Needs, which places each person into a Risk/Need Group ranging from 1 to 8, as depicted in Figure 6.

The grouping into LOW or MED/HIGH along the three axes (Criminogenic Risk[8], MH, and SUD) is based on national screening tools. (See Appendix H.) The MDC Risk/Need Group was developed based on the national Criminogenic and BH Needs Framework, which was adapted from the evidence-based RNR model. This model has been used by CJ professionals for over two decades. The underlying principles are that participants should receive the services they need at the intensity they need, and that they shouldn't receive services they don't need. Research has shown that providing too much or the wrong kind of services fails to improve outcomes and can even make outcomes worse by placing excessive burdens on some participants and interfering with their engagement in activities like work or school.

Figure 6: Risk/Need Group based on MDC screening



[8] Criminogenic risk is the probability that an individual will recidivate. Risk factors include those that are unchangeable or historical in nature (e.g., prior criminal convictions) and those that are potentially changeable (e.g., SUD, limited prosocial activity).

Description of Service Providers at MDC/RRC who support reentry

Organization / Program	Description	MDC	RRC	Community
County/MDC/Administrative Services, including Social Service Coordinators (SSCs)	SSCs serve all individuals in jail (unless they are released too quickly). They visit each pod twice weekly. Caseload size varies by inmate's pod and classification. The type & intensity services they provide will depend on many factors including which other providers are involved. They handle Medicaid enrollments and reactivations. The Director of Administrative Services oversees Centurion, RSNM, and UNM Fast Track contracts (see below). Population served: All. Staffing: 12 SSCs, plus supervisor. Caseload per SSC: 150-225 people.	X		
Centurion	Medical Contractor at MDC as of Feb 2019. In addition to the PAC unit, Centurion also provides psychiatric services to individuals in other units, along with medical care. The correctional officers who staff the PAC receive specialized training in mental health and crisis intervention, with a refresher every 6 months. Most have chosen to work in PAC. Staffing at PAC: 15 FTE. 2 RNs, 5 Psychiatrists, 2 psychiatric RNs, 4 masters-level MH providers, 2 discharge planners. (Discharge Planning is required for all people releasing from PAC.)	X		
Recovery Services of NM (RSNM)	Provides both MDC and community-based treatment for opioid use disorder (OUD). In MDC, the only treatment option is methadone (not buprenorphine). Initially, only maintenance methadone treatment was provided; however, recently RSNM began providing methadone induction services. Staffing: 3 Intake staff, 5 RNs, 4 Counselors, 2 MDs, 1 transition coordinator.	X		X
County/DBHS/Reentry Resource Center (RRC)	Staff from DBHS include: Pam Acosta, Special Projects Coordinator; Jessica Jaramillo, who supervises the Greeters, who staff RRC 24/7. Pam oversees overall program management; Jessica is the RRC supervisor who oversee day-to-day operations.		X	

Description of Service Providers at MDC/RRC who support reentry

Organization / Program	Description	MDC	RRC	Community
	Staffing: 1 greeter, 5 CHWs, 1 TP, and 6 rotating Pathways navigators. Only the greeter is employed by DBHS.			
County/DBHS/Addiction Treatment Program (ATP)	Provides a 4-week MDC-based treatment program for people. ATP is typically court ordered. Each participant receives a week of structured assessment by a licensed clinician, followed by 3 weeks of curriculum. Along with other MATS programs, ATP uses the nationally-recognized Community Reinforcement Approach (CRA). Each ATP participant develops a recovery and after-care service plan. ATP is at full capacity due to court orders; 6-10 week wait to begin the program. Population served: People with SUD; many have co-occurring MH issues. Staffing: LCSW, LADAC, LSAA, Substance Abuse Techs. A case manager who is based in the RRC.	2 pods	X	
UNM Psych / Transition Planners (TP)	TPs serve people with a Risk/Need Group of 6-8, including those that are released quickly. The type and intensity of services depends on Risk/Need Assessment and length of stay, as well as on which other providers are involved. Population served: Individuals with Risk/Need Groups of 6-8. Staffing: 6 TPs, plus supervisor and assistant case manager. One TP is based in RRC. Caseload: 40-60. Funding: Mill Levy.	X	X	
UNM Psych / Fast Track Program (FT)	FT case managers continue to work with clients after release after release from MDC. Referrals are typically submitted by SSC. Clients cannot be referred to FT unless they have a solid release date of 30-60 days and meet the diagnostic criteria, which is verified through Centurion. Individuals remain in the program for up to one month and then are transferred to a Forensics Case Manager for ongoing case management. Population served: People with serious mental illness (SMI). Staffing: 2 case managers. (UNM Psych has an additional 5 community-based forensics case managers.) Caseload: 20.	X		X

Description of Service Providers at MDC/RRC who support reentry

Organization / Program	Description	MDC	RRC	Community
UNM CHWI / RRC CHW Program	Currently, these CHWs work only in the RRC; however, there are plans to have the CHWs continue to provide services in the community (e.g., taking a client to an appointment). Staffing: 4 CHWs, plus supervisor. Funding: Mill Levy.		X	TBD
UNM CHWI / Pathways Program	Pathways is primarily a community-based program. Four of the Pathways organizations contribute 7-8 Navigators to staff the RRC to facilitate connections to community-based services. Navigators continue to work with clients after they leave the RRC. Clients and Navigators select the top pathways to focus on and work together on completing the pathways. The Navigator will work with the client until the pathways are completed.		X	X
UNM CHWI / Intensive Case Manager (ICM) Program	Like Pathways, ICM is primarily a community-based program. One ICM is based out of RRC.	X	X	X
Gordon Bernell (GB) Charter School	A high school designed to accommodate adult students who haven't been in school for a while. 7 locations; MDC is biggest campus (170 students). Curriculum includes dialectical behavior therapy (DBT), science of addiction, and parenting classes. While at MDC, individuals can request a referral to GB via the pod kiosk or SSC; they must meet classification criteria and GB criteria (e.g., cannot already have high school diploma, but allows for GED). GB is currently in flux due to a new state law that limits the ability of adults to attend public schools. They are working on combining funding from Public Education Department (PED) with funding from Higher Education Department (HED) to continue serving adults. Staffing at MDC: teachers, social worker, LMHC.	6 pods		X

Typical approaches and case management services available from MDC/RRC providers

During interviews, the providers we spoke with emphasized the need to show respect to the people they are serving and to use a strengths-based and trauma-informed approach. Nearly all providers provided some types of case management services. Collectively, these include:

- Transition/Discharge planning, including collaborative goal setting

- Benefits enrollment (e.g., Medicaid, SNAP, SOAR)
- Connection to Medicaid MCOs care coordinator
- Housing application & information (VI-SPDAT, shelters)
- Applications for community-based treatment programs
- Establishing medical home / primary care provider
- Education regarding conditions of release, court dates and processes
- Communication and coordination with other MDC, RRC, and community-based providers
- Support getting individual's property back from MDC when this doesn't happen at release
- naloxone/Narcan education and supplies
- Bus passes, clothing, tailored educational materials
- IDs.

Key Steps in an Individual's Flow through the MDC and RRC

In blue, we show the steps that MDC/RRC providers take to help ensure that they make contact with the right individuals at the right time.

In MDC

1. Centurion conducts a **triage screening** to determine whether the individual can be booked immediately or requires medical clearance first. Beginning in August, Centurion will open a second location for triage screening downtown (in same building as RRC). Goal is to decrease the transportation burden when individuals need to be taken to the hospital and to increase the timeliness of getting medical care.
2. Centurion medical staff conduct a **receiving screening**, which collects a variety of medical information, including suicide risk, need for detoxification, and evidence-based tools to assess criminogenic risk and behavioral health needs. The latter determines the person's **Risk/Need Group** (1-8).
    a. This screening may trigger a medical hold that would place the individual in the **PAC unit** (after being booked), in a specialized pod to address, for example, suicide risk, detoxification, or a mental health crisis. (MDC has 5 units, each of which have multiple pods; a pod houses up to 64 people.)
    b. RSNM conducts intake with eligible patients in the **detox pod** who wish to receive **methadone treatment** for OUD. (There are no intakes on Saturdays.)
    RSNM reviews the detox list every day and crosswalks with BHSDStar system. RSNM's processes are dependent on how many days it's been since the individual's last methadone dose.
3. Person is booked and placed in **intake pod**. A SSC staffs this pod. The SSC supervisor distributes the list of SSCs who are staffing each pod to MDC, RRC, and community-based stakeholders to facilitate communication.
4. MDC classification specialists make the **final pod assignment**, which can take up to 72 hours, or longer for people initially placed in the PAC unit. They use Northpointe's COMPAS classification system. Based on the receiving screening, Centurion staff may make recommendations regarding pod assignment.
5. Metro Court intake officer (by video) interviews people who meet certain criteria to see if they are eligible to be released on their own recognizance, without first appearing before a judge.

6. Person has **first court appearance** (via video at MDC) within 24 - 48 hours (depending on day of the week).
    a. Prior to court appearance on felony cases, Metro Court staff conduct a **public safety assessment** (PSA) to inform the judge's custody decision during the first court appearance.
    b. Transition Planners (TP) often make make first contact with individuals with Risk/Need Groups of 6-8 at this court appearance. TP conducts an **assessment**, which helps inform a **transition plan**; individual may sign **Release of Information** (ROI) at this point, too. Many will be rapidly released and won't have contact with any other MDC service providers. Each morning, TP staff get the docket for these first court appearances about 1 hour before they start. They crosswalk the docket with the Risk/Need Groups in Sapphire. TPs puts assessment and transition plan into Sharepoint, so that this information is available to RRC staff.
7. Person is **placed in pod**.
    a. A **SSC** visits the pod twice a week. The SSC schedule is posted in the pod, along with the list of available services. When the SSC arrives, individuals sign-up to speak with him/her. SSC typically spends 1-2.5 hours in a pod.
    b. Other service providers also visit individuals in the pod on an ad hoc basis, including TPs, Public Defender staff, Pretrial Services staff, RSNM, and Centurion. Each morning, TP staff run a report from Sapphire to identify individuals with Risk/Need Groups 6-8 who are in each pod (excluding PAC and releasing pods). This caseload is divided up among TPs.
    c. For patients receiving **methadone treatment for OUD**,
        i. RSNM nurse admits patient,
        ii. MD examines patient and determines dosing,
        iii. counselor reviews initial treatment plan with patient, conducts comprehensive bio-psychosocial assessment within 2 weeks, and sees patient monthly;
        iv. RNs administer dose daily;
        v. Discharge planning happens up front: determines which community-based clinic the patient wants to go to in community and puts packet in their property (e.g., map of community-based clinic, RSNM phone #, etc.)

        If dosing pre-MDC was less than 4 days ago, then RN can administer courtesy dose and patient won't need to see doctor for 14 days (requires signature from community-based MD); else patient must wait to see MDC doctor before receiving treatment.

    d. For individuals participating in 4-week **Addiction Treatment Program**,
        i. SJDC judge orders person to ATP; usually repeat offenses, related to SUD. Typically court order is pre-adjudication, allowing judge to see how person responds to ATP before making a final ruling.
        ii. The Week 1 cohort is moved into the pod on Tuesday afternoons.
        iii. Wednesday is orientation; assessments happen on Thursday and Friday; an Individual Service Plan is established, setting 3 achievable goals.
        iv. Curriculum begins following Monday (Week 2) and participants attend small and large group meetings. Week 4 participants are mixed in with Weeks 2 & 3 participants and act as mentors.
        v. Upon completion, a letter is sent to the judge.

e. For individuals in **Gordon Bernell high school**, when they are moved to the pod, they are given a one-week orientation, receive their state identification, and are enrolled. They also meet their social worker to develop a Next Steps Plan (a PED requirement) and assess their goals.

8. Person is released.
    a. For individuals with certain medical or behavioral health issues, they receive **14 days of medications** if pharmacist is available; if not, a 14-day prescription is written (paid for by the County). In addition, individuals receive a **30-day prescription** (paid for by the individual or their insurance company). Prescriptions can be called in to any one of 8 pharmacies in town. The County is working to expand certain prescriptions to 90 days.
    b. Person's property is returned to him/him. During day shift, they receives their money in the form of a Visa; during off hours they are often instructed to return to MDC to pick it up during business hours.
    c. Person is **transported to RRC**, along with others, in van.

MDC sends RRC an email that lists everybody who is expected on the van an hour or two before the van arrives. RRC staff crosswalk this list with info in Sharepoint to determine individuals' Risk/Need Groups and to review the Assessments and Transition Plans, when available. RRC also gets a "transition services release notice" for each person with a Risk/Need Group 6-8; and typically receives discharge plans from the PAC unit. MDC calls the RRC when the van is leaving MDC; and, upon arrival, hands the RRC Greeter a hard copy of the list of people in the van.

At RRC

9. Van is met outside by **RRC Greeter**, who lets people know about the services available inside the RRC. Inside the RRC, staff are spread out throughout the facility and use Motivational Interviewing and other techniques to engage people.
10. Once an individual is engaged, **RRC staff** conduct a Reentry Needs Assessment. (The individual must do the Assessment in order to receive certain services—e.g., bus pass.)
    At this stage, the RRC-based CHWs, Pathways navigators, and Transition Planner have similar roles and responsibilities. Staff will build off the Assessment done by the MDC Transition Planner, if available. The Sharepoint-based Assessment may include case management notes from prior encounters at MDC or RRC.
    a. RRC staff provide direct services (e.g., a SNAP application), warm handoffs, and referrals, while the individual is still at RRC. Average time with client is 45 minutes. Services may include connection to RRC-based Pathways navigator or Intensive Case Manager, who can directly support the client in the community. RRC staff also provide client with a business card to call back, as needed, for more information or referrals.
    b. Individuals assigned to Pretrial Services (PTS) are provided a ticket which allows them to go upstairs to connect with PTS and then to return to the RRC for other services.
    PTS sends RRC a list of people being released who are assigned to PTS.

Community Corrections (Intercept 5)

Key players at this intercept include:

- The state Correction Department's (NMCD) Probation & Parole Division,
- MDC's Community Custody Program, and
- Metro Court's Probation Division.

The judiciary also plays a key role as probationers are under the jurisdictions of the courts. (Parolees are under the jurisdiction of the state Parole Board.) Judges have the primary responsibility for setting conditions of probation and for imposing sanction for supervision violations.

NMCD Probation & Parole Division (PPD)

PPD supervises about 17,000 individuals a year in NM; about one-third are on felony probation and two-thirds on parole (or both). Over three-quarters are assessed as likely to have a SUD. PPD is separated into four geographic regions (I-IV). Region II includes Bernalillo, Valencia and Sandoval Counties, and it is overseen by 2 Regional Managers—one oversees Standard Supervision; the other oversees Special Programs, which include:

- Intensive Supervision Units, focused on individuals with a high risk for violence;
- Sex Offender Unit; and
- Community Corrections Unit, focused on individuals with high needs that, if not met, put them at a higher risk for reoffending. These individuals tend to have chronic needs such as MH and SUD issues mental health diagnoses, homelessness, severe medical conditions, and multiple unsuccessful attempts at substance abuse treatment, among others. Community Corrections services also include gender-specific supervision and treatment for female offenders with high needs. The duration of Community Corrections outpatient programming is 6 to 12 months.

PPD also includes a statewide Community Corrections Administrator (CCA) that supports all regional offices. CCA handles all treatment, counseling, housing, financial and other needs of the probation and parole population throughout NM. For example, it manages all contracted providers for inpatient and outpatient treatment services, transitional living, residential programs and halfway houses. NMCD's most recent contracts with service providers include performance and outcome reports, with the first round of quarterly reporting beginning September 2019. Some of the services provided to the clients include: treatment for SUD and MH issues, anger management, sex offender treatment and counseling, and education and training regarding domestic violence, gang interventions, parenting, and life skills.

CCA also includes two officers in each region, who are specifically trained to work with individuals with serious mental illness. Lastly, CCA assists in re-entry planning when high need individuals are released from prison.

Risk/Needs Assessment: In 2016, NMCD began using the national COMPAS tool to assess individuals' risk to recidivate and criminogenic needs. It is used with individuals who are entering prison, leaving prison on parole, or beginning probation; it helps to determine what programming and levels of supervision are appropriate. Now that NMCD has been using the tool for about 3 years, it can now begin validating the tool to our NM population. Based on what it has learned during the last 3 years, NMCD is just beginning to shift programming resources accordingly.

Recovery Academies: NMCD also operates two open campus Recovery Academies—one for men in Los Lunas and one for women in Albuquerque—that offer intensive SUD and MH services to individuals releasing from prison and to individuals who are facing violations, as an alternative to incarceration.

Metro Court's Probation Division

While NMCD handles felony probation, Metro Court handles misdemeanor probation.

MDC's Community Custody Program

MDC's Community Custody Program (CCP) is an alternative to incarceration. About 80 to 100 individuals each month are in CCP; they live at home, may continue their employment, and are monitored daily by MDC officers who are based out of the downtown CCP office. (About 70% of the CCP population is employed.) Individuals under CCP may be either pre- or post-adjudication, so CCP has parallels to both pretrial services (PTS) and to probation. A couple key differences include:

-- Individuals are typically placed in CCP without a judge's order—e.g., via a referral from the Public Defender or a self-referral from the MDC kiosks. If the individual meets CCP criteria (e.g., nonviolent offender), and a judge has not explicitly prohibited CCP, then MDC can transfer an individual into CCP without further involvement from the courts or the SJDA.

-- The level of supervision under CCP may be higher than standard supervision under PTS or probation. CCP has 13 officers who supervise participants and each has a caseload of 15 to 20 individuals.

-- When transitioning from MDC to CCP, individuals do not go thru the RRC (because they are still in custody).

Some of the key steps in an Individual's flow through CCP include:

- Inspection of the person's home, and agreement from the primary tenant to comply with all CCP rules (e.g., no alcohol or weapons, full access to the home by MDC officers)
- Intake with the CCP Social Service Coordinator
- Intake with community case manager, who works fulltime with CCP, but is employed by DBHS, rather than MDC. The case manager assesses BH needs, connects individuals to services, and helps with Medicaid enrollment.
- Intake with MDC officer, which includes providing the individual with a GPS bracelet and a breathalyzer. The GPS bracelet is programmed according to the individual's schedule—e.g., when is s/he expected at work, at counseling, etc.
- Individuals:
    - Present to the CCP office twice a week, at randomly scheduled times, for drug testing. They meet face-to-face with their MDC officer during one of these bi-weekly appointments. Individuals are allowed to use medications for opioid use disorder (buprenorphine or methadone), but not medical cannabis.
    - Call CCP twice a day.
    - Attend weekly counseling sessions.
    - Provider 8 hours of community service each week.
- Officers make a random home visit once a week.

Various types of violations are possible (e.g., missing a scheduled breathalyzer test, being at the wrong place at the wrong time, testing positive for alcohol or drugs, missing an appointment, etc.); and various type of sanctions exists—e.g., extra community service, return to MDC. MDC officers have discretion in handling most violations, although certain violations guarantee that individuals will return to MDC and leave CCP (e.g., testing positive for drugs or alcohol or possession of weapons).

CCP has been in place for about 20 years, although it has gone thru some significant changes over time, in particular:

-- The CCP criteria used to be more subjective; they are now black-and-white. Even if a judge orders CCP, it will be denied if the person does not meet the objective criteria.

-- CCP used to charge individuals 10% of their income; currently, the only charge is a one-time $30 fee.

-- CCP used to have a much larger population. The primary reason for the decrease in population was the launch of pretrial services (PTS) in Metro and District courts about 5 years ago and bond reform—i.e., many who would have been eligible for CCP are no longer detained at MDC. (CCP officers' caseloads used to range from 60-70 individuals, compared to 15-20 individuals today.)

Appendix A: Attendees to monthly CJCC D&R meetings

See Appendix D for all Organization acronyms used here.

Organization	First	Last	April	May	June	July	Aug
County							
Board of Commissioners	Maggie	Hart-Stebbins				X	
DBHS	Nancy	Sanchez	X	X	X	X	X
DBHS	Sam	Howarth	X	X	X	X	
DBHS/MATS/ATP	Megan	Aragon				X	X
DBHS/RRC	Jessica	Jaramillo		X		X	X
DBHS/RRC	Pam	Acosta	X	X	X	X	X
MDC/Admin Services	Rosanne	Otero				X	
MDC/Admin Services	Elizabeth	Rangel			X	X	X
City							
APD/CIS	Matt	Dietzel		X	X	X	X
CJCC							
CJCC	Gabriel	Nims	X	X	X	X	X
CJCC	Lisa	Simpson	X	X	X		
CJCC	Nan	Nash				X	
State							
Corrections Dept	David	Selvage		X			
Corrections Dept	Patrick	Gutierrez			X	X	
Corrections Dept	Wendy	Price		X			
Corrections Dept/Reg 2 P&P	Haven	Scogin			X		
HSD/Medicaid	Jeanelle	Romero		X			
HSD/BHSD	Anita	Morales	X			X	
HSD/BHSD	Mika	Tari		X	X		
SJDA	Johnn	Osborn			X	X	X
SJDA	Sierra	Ludington		X	X		
Courts/Metro	Andres	Garcia			X		
Courts/Metro	Courtney	Weaks		X	X		X
Courts/Metro	Gary	Markel			X		
Courts/Metro	Laura	Daniels	X		X		
Courts/SJDC	Lisa	Shatz-Vance	X	X	X		X
Courts/SJDC	Gilbert	Jaramillo	X	X			X
Courts/SJDC	Marshall	Dixon			X		X
Courts/SJDC	Tanya	Tijerina			X	X	
Workforce Connection	Art	Martinez		X		X	
Workforce Connection	Joy	Forehand		X			
Workforce Connection	Michelle	Velarde		X	X	X	X

Organization	First	Last	April	May	June	July	Aug
UNM							
CHWI	Francisco	Ronquillo	X	X	X	X	
CHWI/ICM	Garfield	Lopez				X	
CHWI/RRC CHWs	Karen	Haas			X	X	
Project ECHO	Jessica	Murray		X	X	X	
Project ECHO	Judy	Bartlett	X	X	X	X	X
Project ECHO	Tracy	Smith	X	X	X	X	
Project ECHO	Venice	Ceballos		X		X	X
Project ECHO	Virginia	Sedore				X	X
Psych/TPT	Aaron	Martinez	X	X	X	X	X
Psych/PES	Bridget	McCoy		X			
ISR	Alex	Tonigan		X	X	X	X
ISR	Elise	Ferguson				X	
Community-based Health / Recovery							
Casa de Salud	Anjali	Taneja			X		X
Crossroads for Women	Cory	Lee	X	X		X	
Heading Home	Carol	Brusca		X	X		X
Heading Home	Jodie	Jepson		X			X
Healthcare for the Homeless	Anita	Córdova		X			
Healthcare for the Homeless	Byron	Aken				X	
HopeWorks	Cristy	Hernandez		X			
HopeWorks	Sarah	Alires		X	X	X	X
Presbyterian Health System	Anne	Baker		X			
RSNM	Chanelle	Stoltenberg				X	X
RSNM	Darren	Webb				X	
Community-based Education / Advocacy							
Gordon Bernell	Beth	Dorado	X	X		X	X
NAMI	Robert	Salazar	X	X	X	X	X
Community-based Legal							
LOPD	Carlene	Miller	X		X		
LOPD	Louella	Arellano		X		X	X
LOPD	Maxwell	Kauffman		X	X	X	X
NM CDLA	Megan	Mitsunaga				X	
Other	Kelly	Waterfall	X		X	X	X
Other	Peter	Cubra		X	X		X
		Totals	**18***	**38**	**35**	**39**	**29**

Note: There were a total of 35 participants in the April meeting; however, we only include people in table above who attended at least one meeting since May because that is when we started using the "Planning Team" email list that was developed with input from the County.

Appendix B: Interviews Conducted for System Analysis

See Appendix D for all Organization acronyms used here.

Organization	First	Last
County		
DBHS	Margarita	Chavez
DBHS	Sam	Howarth
DBHS/RRC	Pam	Acosta
MDC/Admin Services	Elizabeth	Rangel
MDC/Admin Services	Rosanne	Otero
MDC/Centurion (medical contractor)	Daryl	Pena
MDC/Centurion (medical contractor)	Dyanne	Leyba
MDC/Centurion (medical contractor)	Judith	Schroeder
MDC/Community Custody Program	George	Garcia
MDC/Community Custody Program	Valerie	Lujan
MDC/Security	Jennifer	Stepp
City		
APD/CIS	Eric	Garcia
APD/CIS	Diane	Dosal
APD/CIS	Matt	Dietzel
State		
HSD/Medicaid	Jeanelle	Romero
HSD/BHSD	Anita	Morales
HSD/BHSD	Mika	Tari
NMCD/PPD/Community Corrections Administrator	Haven	Scogin
SJDA	Adolfo	Mendez
SJDA	Johnn	Osborn
SJDA	Sierra	Ludington
Courts/Metro	Courtney	Weaks
Courts/Metro	Laura	Daniels
Courts/SJDC	Lisa	Shatz-Vance
Courts/SJDC	Gilbert	Jaramillo
UNM		
CHWI/ICM	Claudia	Timmons
CHWI/ICM	Ivette	Bibb
CHWI/RRC CHWs	Karen	Haas
Psych/TPT	Aaron	Martinez
Psych/PES	Bridget	McCoy
ISR	Paul	Guerin

Community-based Health / Recovery		
Heading Home	Carol	Brusca
Heading Home	Jodie	Jepson
Healthcare for the Homeless	Anita	Córdova
HopeWorks	Sarah	Alires
RSNM	Antonio	Lovato
RSNM	Chanelle	Stoltenberg
Community-based Education / Advocacy		
Gordon Bernell	Beth	Dorado
NAMI	Robert	Salazar
Community-based Legal		
LOPD	Carlene	Miller
LOPD	Louella	Arellano
LOPD	Maxwell	Kauffman
Other	Peter	Cubra

Appendix C: National Resources

Federal agencies / contractors

- Department of Justice (DOJ):
  - Bureau of Justice Assistance (BJA)
    - Justice and Mental Health Collaboration Program (JMHCP). The county has a JMHCP grant (Jan 2019 - Dec 2020).
    - BJA's Comprehensive Opioid Abuse Program
  - National Institute of Justice (NIJ): DOJ's research, development and evaluation agency
  - National Institute of Corrections
    - NIC Library
    - NIC's Evidence-Based Practices in the Criminal Justice System: An Annotated Bibliography (2017)
- Council of State Governments (CSG) Justice Center. CSG plays a lot of roles and is heavily involved with New Mexico and Bernalillo County.
  - Justice Reinvestment Initiative: CSG works with states to figure out how best to invest in criminal justice. It began working w/ NM Summer 2018.
  - Mental Health Initiative
    - Stepping Up Initiative: CSG supports counties to reduce the number of people with mental illness in jails. It's been working with Bernalillo for some time.
  - The National Reentry Resource Center
    - What Works in Reentry Clearinghouse
    - Reentry Essentials series
  - Judges' and Psychiatrists' Leadership Initiative
- SAMHSA's GAINS Center for Behavioral Health and Justice Transformation (Run by Policy Research Associates)
  - Other SAMHSA (Substance Abuse and Mental Health Services Administration) Criminal Justice resources

Other National Organizations/Projects

- The Urban Institute's Justice Policy Center
- Safety & Justice Challenge (Supported by the John D and Catherine T. MacArthur Foundation). The County's LEAD program was funded by this initiative.
- National Association of Counties: Justice focus
- National Association of Pretrial Service Agencies
- Arnold Ventures: Criminal Justice
- American Society of Addiction Medicine

Other Organizations

- Treatment Alternatives for Safe Communities (TASC)
- Community Oriented Correctional Health Services (COCHS)
- Transitions Clinic Network "building an innovative healthcare model for individuals returning to the community from incarceration"

Appendix D: Local Organizations and Programs

This is not intended to be a comprehensive list of all relevant organizations or programs.

Governmental Organizations

- Bernalillo County
  - Board of Commissioners
    - Detention Facility Management Oversight Board (link)
    - Addiction Treatment Advisory Board (link)
  - Department of Behavioral Health Services (DBHS) *Administers Behavioral Health Initiative (BHI) funding: Voters approved a county gross receipts tax increase to pay for BH services, bringing in approximately $19M per year. Also administering federal Bureau of Justice Assistance (BJA) grant that is funding the System Analysis being carried out by the CJCC Diversion and Reentry Subcommittee and the addition of boundary-spanning navigators to the RRC.*
    - Metropolitan Assessment and Treatment Services (MATS) (link) *Offers a continuum of programs and a centralized intake, including triage services which run 24/7. Historically, their focus has been on SUD, but they are aggressively expanding their capacity to address MH.*
    - Reentry Resource Center (RRC)
    - Short Term Housing / Sober Living. *RFP in process. Housing vouchers for adults with BH issues.*
  - Housing Department (link)
    - Community Connections Supportive Housing (link). *Provides intensive case management services linked with scattered site housing to homeless or precariously housed persons with mental illness or co-occurring disorders or other disabilities whose lack of community-based services have resulted in CJ involvement.*
  - Metropolitan Detention Center (MDC)
    - Administrative Services
    - Centurion (medical contractor)
    - Community Custody Program (CCP) (link)
    - McClendon (link)
    - Security
  - Sheriff's Office (BCSO)
    - Mobile Crisis Teams (MCT)
    - Law Enforcement Assisted Diversion (LEAD)
- City of Albuquerque (CABQ)
  - 911
  - Albuquerque Fire Rescue (AFR)
  - Family and Community Services
  - Forensic Intervention Consortium (FIC)
  - Police Department (APD)
    - Crisis Intervention Section (CIS)
    - DOJ Court-Approved Settlement Agreement (CASA) (link)
      - Mental Health Response Advisory Committee (MHRAC) (link)
    - McClendon (link)
- Criminal Justice Coordinating Council (CJCC) (link)

    - Diversion and Reentry Subcommittee
    - Data and Technology Subcommittee
- Albuquerque Bernalillo County Government Commission (ABCGC) (link). *Joint City/County Commission made up of elected officials. Oversees the Behavioral Health Initiative (BHI).*
- State of NM (link)
    - Behavioral Health Collaborative (link). *Cabinet-level group represents 15 state agencies and the Governor's office, involved in BH prevention, treatment, and recovery.*
    - Corrections Department (CD)
        - Probation & Parole Division (PPD)
            - Region 2 Standard Supervision
            - Region 2 Special Programs
            - Community Corrections (statewide)
    - Department of Health (DOH)
        - NM Behavioral Health Institute (link). *The only state owned and operated psychiatric hospital in NM.*
    - Department of Public Safety (DPS)
        - State Police
    - Department of Workforce Solutions
    - Human Services Department (HSD)
        - Medical Assistance Division (Medicaid)
            - Centennial Care 2.0 (link) *Most NM Medicaid beneficiaries fall under this program, which in federal-speak is an 1115 Demonstration Program. "Demonstration" is a bit of a misnomer—Centennial Care began in January 2014 and is approved through December 2023.*
            - CareLink (link) *The Medicaid Health Home State Plan Option, authorized under the Affordable Care Act, allows states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions. In NM the program is called CareLink and is targeted to adults with SMI or children with severe emotional disturbance (SED). The MCOs delegate care coordination to a local provider. In Bernalillo, the two CareLink providers are UNM Psych and NM Solutions.*
            - JUST Health Program (Justice-Involved Utilization of State-Transitioned Healthcare) (link)
        - Behavioral Health Services Division (BHSD)
    - Judicial
        - Administrative Office of the Courts (AOC)
        - Administrative Office of the District Attorney
            - Second Judicial District Attorney (SJDA) (link)
        - Bernalillo County Metropolitan Court (Metro) (link)
            - Probation Division. *Handles pretrial services (PTS), post-adjudication probation supervision, and Specialty Courts.*
        - Second Judicial District Court (SJDC)
            - Assisted Outpatient Treatment Program (AOT) (link)
            - Pretrial Services (PTS)
            - Specialty Courts

    - Regulation and Licensing Department. *The County is working with the State to develop a pilot program that would allow individuals to obtain state ids using their MDC booking sheet, possibly at the RRC.*
- New Mexico VA Health Care System (NM VA)
    - Veterans Justice Outreach (link)
- Mid-Region Council of Governments (COG)
    - Workforce Connection of Central NM (link)

University of New Mexico Organizations (UNM) Organizations

- Health System (link)
    - Emergency Department (ED)
    - Office of Community Health (OCH)
        - Community Health Worker Initiatives (CHWI)
            - Intensive Case Manager Program (ICM)
            - Pathways Program
            - RRC CHW Program
    - NM Poison and Drug Information Center (link)
    - Project ECHO. *Funded by the County to conduct this System Analysis in collaboration with the CJCC Diversion and Reentry Subcommittee.*
    - Psychiatric Center
        - Addiction and Substance Abuse Program (ASAP) (link). Includes dual-diagnosis clinic (MH & SUD).
        - CareLink (link)
        - Comprehensive Community Support Services (CCSS) (link)
        - Inpatient
        - Primary Care (ICOPE) (link)
        - Psychiatric Emergency Services (PES)
        - Psychosis Early Intervention Programs (link)
        - Urgent Care
- Institute for Social Research (ISR) (link) *Has a long history of reporting on and working with local data systems related to CJ and BH programs.*
    - NM Sentencing Commission (link)

Community-based and Other Organizations

- Health / Recovery
    - Albuquerque Center for Hope and Recovery (link). *Services include BHI-funded Peer Drop-in Centers.*
    - Albuquerque Health Care for the Homeless (AHCH) (link). *Among many other services, AHCH provides a variety of outreach services.*

  Related national models / initiatives: Stepping Up Strategy Lab: Homeless outreach teams

    - Casa de Salud (link)
    - Centro Sávila (link)
    - Crossroads for Women (CRFW) (link). *Programs focused on housing and peer support for women either in transition from incarceration or domestic violence victims. In-reach to MDC and prisons to assess for services.*
    - First Choice Community Healthcare (FCCH)
    - First Nations Community Healthsource (FNCH)

    - HopeWorks (link). *Among other services, HopeWorks is partnering with City and County to develop a single-site Permanent Supportive Housing project that will provide 40-60 units for adults with BH issues.*
    - NM Crisis And Access Line (NMCAL) (link)
    - NM Hope (link)
    - NM Solutions (link)
        - CareLink
    - Presbyterian Health System
    - Recovery Services of NM (RSNM)
    - Steelbridge Ministries (link)
    - Therapeutic Living Services (link)
    - Lovelace Health System
- Education / Advocacy
    - Gordon Bernell Charter School (link)
    - MITC (link). *They are BHI-funded to provide a free 13-hour training on Motivational Interviewing to the Bernalillo workforce supporting individuals with BH issues.*

  Related national models / initiatives: Stepping Up Strategy Lab: Motivational Enhancement Therapy (Motivational interviewing)

    - National Alliance on Mental Illness ABQ (NAMI) (link)
- Housing. *We have not inventoried local housing options (e.g., transitional housing, permanent support housing, respite beds, residential treatment programs). A partial list of organizations providing housing options includes: Crossroads for Women, DBHS/MATS/Supportive Aftercare Community Program, HopeWorks, Therapeutic Living Services.*
    - NM Coalition to End Homelessness (NMCEH) (link)
    - Heading Home (link)
        - Albuquerque Opportunity Center (AOC) (link). *Includes both an emergency housing and respite care program. The latter has 30 beds and provides care to men recently released from the hospital; UNM provides medical care. Respite beds can save hospitals money and help ensure that individuals experiencing homelessness are not released to the streets when they need more care.*
- Legal
    - Law Offices of the Public Defender (LOPD). *Clients must meet eligibility requirements based on household income and assets. Caseworkers assigned to high-needs clients and begin working clients in MDC, RRC, or upon release; and help with housing and transportation needs and navigating the court system, for example.*
    - NM Criminal Defense Lawyers Assoc (NM CDLA)
- Benefits
    - Medicaid Managed Care Organization (MCO)
        - Blue Cross Blue Shield (BCBS)
        - Presbyterian Health Plan (PHP)
        - Western Skies (Western)
    - NMCEH / SSI/SSDI Outreah, Access, and Recovery (SOAR) (link)

  Related national models / initiatives: PRA: SOAR Works

Appendix E: Glossary of Acronyms

- BH: Behavioral Health
- CJ: Criminal Justice
- CMS: Client Management System
- EMR: Electronic Medical Record
- FTE: Full Time Equivalent
- HIE: Health Information Exchange
- HUD: Housing Unnerving Development
- JMS: Jail Management System
- MH: Mental Health
- MOU: Memorandum of Understanding
- NMSA: New Mexico Statute Annotated
- OUD: Opioid Use Disorder
- PTU: Prisoner Transport Unit
- RFP: Request for Proposal
- RNR: Risk Need Responsivity
- ROI: Release of Information
- SED: Severe Emotional Disturbance
- SIM: Sequential Intercept Model
- SMI: Serious Mental Illness
- SSC: Social Service Coordinator
- SUD: Substance Use Disorder
- TP: Transition Planner

Appendix F: Brief Guide to this Report's 25 Recommendations

For a longer description of each recommendation below, see Section above.

Column definitions for the table below

- **Stepping Up Measures**: We use the Stepping Up icons (defined on page 3) to specify which measures each recommendation is working towards. (We don't label any recommendations as directly related to reducing recidivism, as this results from the effect of the prior measures.)
- **Consensus**: During our August 27 CJCC D&R Subcommittee meeting, we conducted an activity to assess the level of consensus regarding each recommendation. We asked participants to put their thumbs up if they agreed with the recommendation; thumb sideways if they had some doubts or concerns but could let the recommendation stand; and thumbs down if they were opposed. The vast majority of participants put their thumbs up for all recommendations. Below we show the handful of recommendations that had at least 3 participants with a sideways thumb or any participants with a thumbs down.
- **Impact / Effort**: During the August 27 meeting, we also did a quick assessment of participants' perceptions regarding the impact that each recommendation could have—in particular on the 4 key Stepping Up measures—and on the effort required to implement the recommendation. In retrospect, our findings would have been easier to interpret if we had provided a definition for Effort. It became clear during the activity that some participants were including resources/dollars in their definition, while others were not. The full results of the activity are shown in Appendix I. In the table below, we highlight a handful of recommendations that stood out because of a relative consensus regarding High or Low Impact or High or Low Effort.
- **Lead Role**: Lastly, during the August 27 meeting, we broke into to 4 small groups to discuss which entity would be well suited to take ownership of each recommendation. We proposed 5 broad categories—City/County, CJCC, CJCC Subcommittee, Other existing Committee, and Other—and encouraged the groups to write in more specific entities as appropriate. It was clear from this activity that each recommendation will likely require different types of investment by different types of entities (e.g., funder, policy maker, service provider, researcher). Below, we highlight a handful of recommendations with a relative consensus regarding which entities should take a lead role.

	Recommendations	Stepping Up Measures	Consensus	Impact	Effort	Lead Role
Developing Collaborative Approaches across our BH/CJ System (Cross-intercept Approaches)						
1	Now that we have a relatively a large selection of diversion and reentry interventions, shift resources towards improving existing interventions and improving collaboration and coordination across the overall BH/CJ system. a. Dedicate City/County/CJCC staff time towards improving collaboration and coordination and foster an engaged and representative CJCC D&R Subcommittee. b. Create an ombudsman-like role to allow agencies to share and resolve concerns. c. Bridge knowledge gaps and cultural divides among stakeholders.			High		
2	Continue to develop and improve (human and data) systems for collaboration and coordination. a. Use local and national resources to build expertise about information sharing protocols that decrease client burden, improve continuity of care, and protect privacy. b. Adopt and tailor elements from the national Collaborative Comprehensive Case Planning model to our BH/CJ system. c. Develop protocols for coordination among providers who interact with clients at MDC.					
3	MDC and DBHS are in the process of selecting and implementing a new Jail Management System (JMS) and Client Management System (CMS). Develop a prioritized list of features for these new systems that could bring value to the BH/CJ system.					
4	Work with key stakeholders at each Intercept to voluntarily and routinely submit measures regarding interactions with people with BH issues.					CJCC, CJCC D&R

Recommendations		Stepping Up Measures	Consensus	Impact	Effort	Lead Role
5	Develop and implement routine monitoring of the four Stepping Up measures (MDC bookings, length of stay at MDC, recidivism, connection to community-based services) for people with BH issues. a. Develop agreement around key definitions					CJCC, ISR
6	Assess the extent to which the intensity of services provided matches individuals' risks and needs.			High		
7	Use case conferencing to monitor and improve our BH/CJ system.			Low	High	
8	Identify key principals and evidence-base practices that are applicable across our BH/CJ system, assess their current application, and identify opportunities for expansion.					
Community-based Supports and Services (Intercept 0)						
9	Inadequate access to a continuum of community-based services contributes to a disproportionate number of people with BH issues in our jail. Continue to understand and address the most urgent unmet needs. a. Address both the perception and the reality that accessing BH services is easier inside the CJ system than outside the CJ system.			High	High	
10	Coalesce around a single online resource directory that can be tailored to individuals with CJ involvement and BH issues.			Low		
11	Identify and support community-based organizations who wish to better serve their clients with BH issues and CJ involvement.					RRC, CJCC D&R
12	Diversion involves two critical steps: exiting the CJ system and connecting to community-based services. Ensure that the latter step happens, especially for our most vulnerable residents.			High	Low	

Recommendations		Stepping Up Measures	Consensus	Impact	Effort	Lead Role
13	When diversion from the CJ system is appropriate, ensure that it happens as early as possible. Expand diversion options at Intercept 0 a. Develop and pilot protocols for diverting appropriate calls from 911 to NMCAL. Explore other alternatives to calling 911 for families and individuals experiencing mental health crises. b. Pilot Mobile Crisis Teams that do not involve law enforcement.					
Law Enforcement (Intercept 1)						
14	Continue to expand LEAD and other early diversion back to Intercept 0.					County, APD, BCSO
15	Explore whether APD's Prisoner Transport Unit (PTU) could become a targeted site for diversion, leveraging the existing medical and BH screening of individuals at this intercept.			Low	High	
16	Explore alternatives to current transport protocols for psychiatric evaluations.					
The Court System (Intercepts 2 and 3)						
17	Periodically convene stakeholder meetings focused on continuing to improve our Specialty Courts.					CJCC, CJCC Subcommittee
18	Continue to adopt evidence-based practices within Metro and SJDC pretrial services (PTS), and improve continuity between Metro and SJDC PTS.					CJCC, CJCC Subcommittee
19	Monitor the impact of the new state rules regarding competency proceedings.			Low		CJCC, CJCC Subcommittee
20	Reach broader agreement about whether, when and how to use involuntary civil commitment. Increase awareness and understanding of the new state law regarding Assisted Outpatient Treatment (AOT).					

Recommendations		Stepping Up Measures	Consensus	Impact	Effort	Lead Role
MDC and RRC-based Reentry Services (Intercepts 2-4)						
21	Continue to expand and improve boundary-spanning activities.					
22	Cross-training and relationship building between reentry service providers and MDC leadership and correctional officers may help improve reentry services.					
23	Continue to increase outreach and marketing to ensure that individuals with BH issues and CJ involvement—and community-based organizations that serve these individuals—are aware of MDC- and RRC-based reentry services.					
24	Address barriers that patients face in receiving timely, effective treatment for opioid use disorder in MDC and when they transition back to the community. a. Address barriers to receiving timely methadone treatment in MDC. b. Accelerate the introduction of buprenorphine as a treatment option for OUD in MDC. c. Ensure that medication treatment for OUD is fully integrated into our BH/CJ system.					
Community Corrections (Intercept 5)						
25	Advocate for HB 564 during next legislative session. Work with stakeholders to build support and to address outstanding concerns regarding this bill to strengthen probation and parole supervision practices.					

Appendix G: Data Systems

Parent Organization	Data System Name	Description	Access to Data System
County / MDC	EJS	Current Jail Management System (JMS). A new JMS is in development and will be implemented within a year or so. EJS includes information, for example, about movement through MDC, arrest records, sentencing and court dates. SSCs put their client notes in EJS and can extract performance measures. EJS now sends automated, person-specific email notices to TP/RRC staff about 1 to 3 hours before a person with a Risk/Need Group of 6-8 will be released. This allows, for example, the SSC supervisor to verify whether Medicaid is in place and the TP supervisor to wrap up Transition Plan. EJS also has an interface with the state's Medicaid system: * EJS shares daily booking and release information with Medicaid * Medicaid shares eligibility information with MDC daily * Benefits are systematically suspended for individuals after 30 days of incarceration * Benefits are automatically reactivated once Medicaid receives release data from MDC	MDC staff (e.g., SSCs), TPs, some DBHS staff RRC CHWs don't have full access; they receive notices of release.
County / MDC	CCP database	CCP uses a standalone MS Access database. They currently do not create any routine reports to monitor the program. They anticipate being incorporated into the new JMS.	
Centurion	Sapphire	Electronic Medical Record (EMR). Includes information about the Receiving Screening that is conducted at booking, which assigns each person a Risk/Need Group from 1 to 8.	Transition Planners (TP) and SSCs have full access. RRC CHW supervisor has access to Risk/Need Groups and medications.
County / DBHS	Sharepoint	SharePoint is a work-around until a more appropriate Client Management System (CMS) is put in place. Currently includes: TP/RRC Assessment, Transition Plan, spreadsheets to track RRC CHW measures (e.g., number of VI-SPDATs completed; successful referrals to Pathways and ICM). BernCo recently issued an RFP for a Reentry Program CMS. Proposals were due in mid-May and a finalist will likely be selected this summer. Section IV, beginning on p 14, lists the various BernCo and BHI-funded programs that would be included in this CMS. It may be implemented in stages starting, for example, the MDC/RRC providers.	RRC-based staff, SSCs, TPs No access: RSNM

Appendix G: Data Systems

Parent Organization	Data System Name	Description	Access to Data System
County / DBHS	Metropolitan Assessment and Treatment Services (MATS)	All MATS providers (including ATP staff) use a web-based client management system; this will be replaced by new CMS discusses above. MATS also pulls data from their current CMS and other sources to identify high utilizers: It combines data from all MATS programs, MDC incarcerations; Risk/Need Groups from Centurion's EMR, and ED and hospitalizations from HIE (see below). Eventually, it would like to include a wellness score, too. The system will serve two roles: 1. Provide alerts to staff at MATS, MDC-based Transition Planning Team, and RRC to intensify services for these individuals and to make contact as quickly as possible. 2. Provide data to evaluate the impact of interventions by comparing utilization data pre/post intervention.	ATP and other MATS programs
State / Courts	Secured Odyssey Public Access (SOPA, aka Odyssey)	Detailed information about criminal (and civil) cases. Metro Pretrial Services (PTS) sends RRC a list of people being released who are assigned to PTS.	Public has access to Case Lookup. Some MDC/RRC users have higher level access: SSCs, TPs (not RRC CHWs).
State / NMCD	OMNI	NMCD expects to go live with OMNI within a year. Features will include: improved methods for sharing data and interfacing with other data system (e.g., NM State Police); improved reporting systems; and a portal for community-based providers.	
State / HSD / BHSD	BHSDStar	RSNM uses this system to verify whether and where patients are receiving methadone treatment.	
NM Coalition to End Homelessness	Coordinated Assessment System	Agencies that participate use a common assessment tool (VI-SPDAT) to determine what types of housing and support would best help a homeless individual or family obtain housing. Part of the Homeless Management Information System.	MDC/RRC fill out VI-SPDATs for individuals; not clear if they are able to login into system to verify client's status.
NM Health Information Collaborative	Health Information Exchange (HIE).	The HIE allows authorized professionals with patient consent to the patient's health history from a variety of healthcare organizations. Sources of HIE data.	
State / DOH	Vital statistics	CJCC Data and Tech Subcommittee Wish List: Link to courts system	

Appendix H: Individual tools used to determine Risk/Need Group during MDC screening

The grouping into LOW or MED/HIGH along the three axes (Criminogenic Risk, Mental Illness, and Substance Use) is based on national, validated screening tools. Each tool is made up of several questions that Centurion staff ask individuals (i.e., self-report).

Criminogenic Risk tool: Proxy Risk to Recidivate

1. How old are you?
2. If arrested previously, how old were you at your first arrest?
3. How many times have you been arrested previously?

Mental Illness tool: Brief Jail Mental Health Screen (BJMHS)

Questions		**No**	**Yes**	**General Comments**
1	Do you currently believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?			
2	Do you currently feel that other people know your thoughts and can read your mind?			
3	Have you currently lost or gained as much as two pounds a week for several weeks without even trying?			
4	Have you or your family or friends noticed that you are currently much more active than you usually are?			
5	Do you currently feel like you have to talk or move more slowly than you usually do?			
6	Have there currently been a few weeks when you felt like you were useless or sinful?			
7	Are you currently taking any medication prescribed for you by a physician for any emotional or mental health problems?			
8	Have you ever been in a hospital for emotional or mental health problems?			
(Optional): Officer's Comments/Impressions (check all that apply):				
___Language barrier ___Under the influence of drugs/alcohol ___Non-cooperative ___Difficulty understanding questions ___Other, specify:_____				

Policy Research Associates, Inc. (2005)

Substance Use tools: Alcohol Use Disorders Identification Test-Consumptions (AUDIT-C), the Drug Abuse Screening Test (DAST-10), and the Opioid Risk Tool.

The Alcohol Use Disorders Identification Test-Consumptions (AUDIT-C)					
For each question, circle the best answer					
1. How often did you have a drink containing alcohol in the past year?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2. How many drinks did you have on a typical day when you were drinking in the past year?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often did you have 6 or more drinks on one occasion in the past year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Bush, K, Kivlahan, McDonell, et. al. (1998) The AUDIT Alcohol Consumption Questions (AUDIT-C)

Drug Abuse Screening Test (DAST-10)			
In the past 12 months…		**Circle**	
1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you abuse more than one drug at a time?	Yes	No
3	Are you unable to stop abusing drugs when you want to?	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you ever feel bad or guilty about your drug use?	Yes	No
6	Does your spouse (or parents) ever complain about your involvement in drugs?	Yes	No
7	Have you neglected your family because of your use of drugs?	Yes	No
8	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No
Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.			

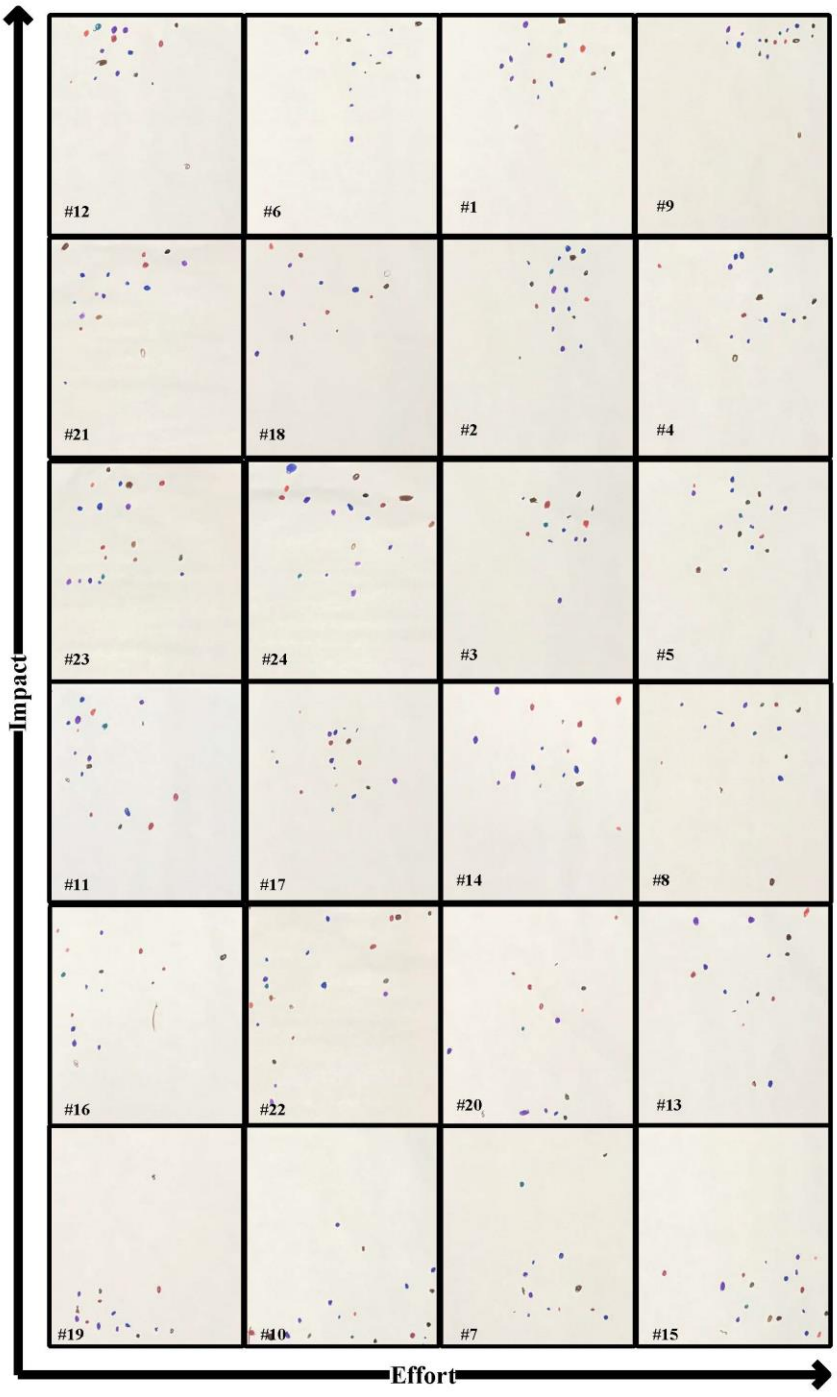
Skinner HA (1982). The Drug Abuse Screening Test-10

Opioid Risk Tool:

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Appendix I: Raw Results from Aug. 27 Activity to Prioritize Recommendations

See Appendix F for more details and for the recommendations corresponding to the numbers in the graphic below.



Appendix J: Bernalillo County 2015 Stepping Up Resolution

BERNALILLO COUNTY
BOARD OF COUNTY COMMISSIONERS
ADMINISTRATIVE RESOLUTION NO. 2015-37

A RESOLUTION TO ADOPT THE NATIONAL ASSOCIATION OF COUNTIES STEPPING UP INITIATIVE TO REDUCE THE NUMBER OF PEOPLE WITH MENTAL ILLNESS IN THE METROPOLITAN DETENTION CENTER

WHEREAS, counties routinely provide treatment services to the estimated 2 million people with serious mental illnesses booked into jail each year; and

WHEREAS, prevalence rates of serious mental illnesses in jails are three to six times higher than for the general population; and

WHEREAS, almost three-quarters of adults with serious mental illnesses in jails have co-occurring substance use disorders; and

WHEREAS, adults with mental illnesses tend to stay longer in jail and upon release are at a higher risk of recidivism than people without these disorders; and

WHEREAS, county jails spend two to three times more on adults with mental illnesses that require interventions compared to those without these treatment needs; and

WHEREAS, without the appropriate treatment and services, people with mental illnesses continue to cycle through the criminal justice system, often resulting in tragic outcomes for these individuals and their families; and

WHEREAS, Bernalillo County takes seriously its responsibility to protect and enhance the health, welfare and safety of its residents in efficient and cost-effective ways; and

WHEREAS, Bernalillo County has an obligation to protect the health and safety of Metropolitan Detention Center (MDC) corrections staff and inmates; and

WHEREAS, the population at MDC has dropped significantly over the past 18 months through initiatives developed by Bernalillo County and its partners in the criminal justice system; and

WHEREAS, MDC has begun implementing a pilot program to enroll inmates in New Mexico's Medicaid system; and

WHEREAS, Bernalillo County has allocated $1 million to create 70 supportive housing units for individuals who are incarcerated but eligible for release and who have been identified as having a mental illness, substance abuse or co-occurring disorders, and are homeless or precariously housed, and to connect this vulnerable population with resources and services that promote stability and prevent recidivism; and

WHEREAS, the Bernalillo County Commission has implemented a 1/8 cent gross receipts tax to expand access to behavioral health services; and

WHEREAS, Bernalillo County has engaged a consultant to advise the County Commission on the development of a behavioral health "business plan", to include strategies for alternatives to incarceration for residents with behavioral health disorders; and

WHEREAS, through *Stepping Up* , the National Association of Counties, the Council of State Governments Justice Center and the American Psychiatric Foundation are encouraging public, private and nonprofit partners to reduce the number of people with mental illnesses in jails;

NOW, THEREFORE, BE IT RESOLVED by the Bernalillo County Board of County Commissioners does hereby commit to continuing efforts to reduce the number of people with mental illnesses in the MDC; commit to sharing lessons learned with other counties in New Mexico and across the country to support a national initiative and encourage all county officials, employees and residents to participate in *Stepping Up*. We resolve to utilize the comprehensive resources available through *Stepping Up* to:

1. Convene or draw on a diverse team of leaders and decision makers from multiple agencies committed to safely reducing the number of people with mental illnesses in jails.
2. Collect and review prevalence numbers and assess individuals' needs to better identify adults entering jails with mental illnesses and their recidivism risk, and use that baseline information to guide decision making at the system, program, and case levels.
3. Examine treatment and service capacity to determine which programs and services are available in the county for people with mental illnesses and co-occurring substance use disorders, and identify state and local policy and funding barriers to minimizing contact with the justice system and providing treatment and supports in the community.
4. Develop a plan with measurable outcomes that draws on the jail assessment and prevalence data and the examination of available treatment and service capacity, while considering identified barriers.
5. Implement research-based approaches that advance the plan.
6. Create a process to track progress using data and information systems, and to report on successes.

DONE this 12th day of May, 2015

Signed by BOARD OF COUNTY COMMISSIONERS